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CHAPTER/SUB-SECTION

Section 1.1 How to Use the CPPM

The Contractors Policy and Procedure Manual (CPPM) introduces and describes the Children's Rehabilitative Services (CRS) Program, its financing, organization, and administration in the State of Arizona. It also includes the interfaces between the CRS Program and other state and federal agencies and organizations.

This manual contains the policies and procedures necessary for the operation of Arizona's Children's Rehabilitative Services (CRS) Program. These policies and procedures are established by the Arizona Department of Health Services (ADHS)/Office for Children with Special Health Care Needs (OCSHCN)/Children's Rehabilitative Services Administration (CRSA) to implement pertinent laws and regulations, including the Arizona Revised Statutes, Code of Federal Regulations, Arizona Administrative Codes and such rules, regulations and policies, as established by the Director of the Arizona Department of Health Services.

The contents of this manual are divided into chapters. Chapters are then divided into sections numbered serially in Arabic numerals. Sections are subsets of chapters numbered serially in Arabic numerals preceded by a decimal. As an example: "1.0, 2.0, 3.0", etc. are the chapter numbers; whereas, "1.1, 1.2, 2.1, 2.2, 2.3", etc. identify sections within chapters 1.0 and 2.0 and so forth.

Section 1.2 Contract Monitoring and Required Documents

A. Contract Monitoring

Arizona Department of Health Services (ADHS) and any other appropriate agent of the State or Federal Government, or any of their duly authorized representatives, shall have access during reasonable hours to the Children's Rehabilitative Services (CRS) Contractor's facilities and the right to examine the contractor's books, documents, and records involving transactions related to their contract with ADHS/Children's Rehabilitative Services Administration (CRSA).

B. Development, Dissemination, and Revision of the Contractor's Policy and Procedure Manual (CPPM)

1. Where there is a conflict between rule and policy, the rule takes precedence. CRS rules are contained in A.A.C. R9-7-101 to A.A.C. R9-7-705.
2. All CRS policies and subsequent revisions are to be approved by the CRSA. Policies will be prepared, reviewed, and revised in consultation with the CRSA Medical Director, Contractor Medical Directors, and Administrators. Parent Action Council members will also be invited to provide input and comments to proposed policies or revisions. The implementation of ADHS/CRSA policies shall be coordinated among the CRS Contractors and others, as applicable, to ensure operating consistency throughout the CRS Program. Policies will be reviewed at least annually. Based on the policy reviews, necessary policy revisions will be made in accordance with the above procedures.
3. Upon the development or revision of a policy, notification will be made to all appropriate State agencies, CRS Contractors, and regional Parent Action Councils.

C. Provider Manuals

1. CRS Contractors shall:
   a. Develop and maintain a Provider Manual based on a template provided by ADHS/CRSA;
   b. Make the Provider Manual available to all contracted providers; and
   c. Submit the Provider Manual annually to ADHS/CRSA for review and approval.
2. Provider Manuals must:
   a. Be organized and in a style that is easy to follow;
   b. Contain current information;
   c. Contain a signature of the CRS Contractor Administrator indicating their review and approval of the manual;
   d. Have a date of the last update; and
   e. At a minimum include:
      i. An introduction to the CRS Contractor explaining its organization and administrative structure;
      ii. The providersô responsibility and the CRS Contractors' expectations of the providers to include their role in quality and utilization management initiatives;

iii. An overview of the CRS Contractor's Provider Service department and function;
iv. A listing and description of covered and non-covered services, requirements and limitations;
v. Emergency Room utilization (appropriate and non-appropriate use of the emergency room);
vi. Dental services;
vii. Referrals to specialists and other providers to include, when applicable, coordination of services with Arizona Health Care Cost Containment System (AHCCCS) Health Plans/ALTCS Plans and their providers;
viii. A listing of enrollee rights and responsibilities as outlined by CRSA with a notation that the providers must provide care in accordance with these rights;
ix. A statement that the provider is not restricted from advising or advocating on behalf of an enrollee who is his/her patient for the following:
    1) The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
    2) Any information the enrollee needs in order to decide among all relevant treatment options;
    3) The risks, benefits, and consequences of treatment or non-treatment; and
    4) The enrollee's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
x. A statement notifying the providers that with the enrollee's written consent, they have the right to act on behalf of the enrollee and file an appeal;
xi. Copies of any CRS Practice Guidelines;
xii. Copy of the CRSA Peer Review Policy;
xiii. Claims disputes and hearing rights;
xiv. Billing and encounter submission information;
xv. An indication of the form, UB92, HCFA 1500, or Form C that is to be issued for services;
xvi. An indication of the fields required for a claim to be considered acceptable by the CRS Contractor;
xvii. Completed samples of UB92, HCFA 1500, or Form C;
xviii. CRS Contractor's written policies and procedures which affect the provider(s) and/or the provider network including:
    1) Claims re-submission policy and procedure;
    2) An explanation of remittance advice;
    3) Prior authorization requirements;
    4) Claims medical review;
    5) Concurrent review;
    6) Fraud and Abuse;

7) How to access formularies; and
8) ADHS/CRSA appointment standards.

xix. Information on how to obtain educational materials and to access interpretation and translation services for members who have Limited English Proficiency (LEP) or prefer to speak a language other than English, or who use Braille or sign language;

xx. Americans with Disabilities Act (ADA) requirements when providing services outside the CRS Clinic setting;

xxi. A statement that providers are required to provide members with information regarding their health care including available treatment options and alternatives in a manner appropriate to the member's condition and ability to understand;

xxii. A statement that providers must allow members to participate in decisions regarding their health care, including the right to refuse treatment;

xxiii. A statement that providers are required to assist members with Limited-English Proficiency (LEP) at all points of contact including providing sufficient access to interpreters and ensuring the qualifications of bilingual staff;

xxiv. A statement that providers and staff are to treat all members with respect, dignity, and consideration for privacy;

xxv. A statement that in the process of coordinating care, each member's privacy is protected in accordance with privacy requirements;

xxvi. A statement that medical records and any other health and enrollment information that identifies a particular member must be confidential, according to requirements of Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-91, Title II;

xxvii. Providers need to ensure that members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

xxviii. CRS member's have the right to obtain a second opinion free of charge from an appropriately qualified health care professional and providers may need to assist the member with a referral to the CRS Contractor;

xxix. The member must be free to exercise his/her rights, without adversely affecting the way the providers and their staff treat the member;

xxx. Providers are to provide information on advance directives to adults (18 years and older) and to acknowledge the member's rights under the law of the State to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

xxxi. Providers must document in the medical record whether or not the individual has executed an advance directive and must not contain the provision of care or otherwise discriminate against an

individual based on whether or not the individual has executed an advance directive;

xxxii. Providers have the right to file a grievance (complaint, expression of dissatisfaction) with the Contractor. A provider, acting on behalf of the member with the member's written consent, may file an appeal. A provider may file a grievance or request a State Administrative Hearing on behalf of the member;

xxxiii. Providers have the right to file an appeal of a medical service denial, suspension, or reduction on behalf of a member with the member's written consent;

xxxiv. Providers have been given specific information about timelines for filing an appeal;

xxxv. Upon request of a member, the provider must provide them with a copy of the member's medical records and respond to a request that may be amended or corrected;

xxxvi. Provide cultural competency information, notification about Title VI of the Civil Rights Act of 1964, Culturally Linguistically Appropriate Services (CLAS) standards and Limited English Proficiency (LEP). Providers should also be informed of how to access interpretation and translation services to assist recipients who are LEP and speak a language other than English or who use sign language.

xxxvii. Reimbursement, including reimbursement for dual eligible members (i.e., Medicare and Medicaid) or members with other insurance. Cost sharing responsibility;

xxxviii. Information on the False Claims Act provisions of the Deficit Reduction Act; and

xxxix. Eligibility verification (i.e., use of PMMIS, DES IVR system, contacting local DES/FAA offices, AHCCCS Online for Providers).

D. Member Handbook

CRSA will provide an electronic version of the CRS Member Handbook. The Contractor shall be responsible for printing and distributing the handbook.

E. New Member Orientation Packet

1. CRS Contractor shall:
   a. Develop a New Member Orientation Packet based upon a template provided by CRSA,
   b. Distribute the New Member Orientation Packet to all new members or the member's family, within ten (10) days of the receipt of notification of the enrollment date; and
   c. Submit the New Member Orientation Packet annually to CRSA for review and approval.
2. New Member Orientation Packets must:
   a. Contain a current CRS Member Handbook;
   b. Contain a comprehensive directory of the CRS Contractor's Clinic Providers, which includes:
      i. Specialty clinic providers' names;
      ii. Specialty clinic telephone numbers;

iii. Providers address
iv. Non-English languages spoken by the providers;
v. The date of last revision;
vi. Any restrictions or an explanation of the members' freedom of choice among clinic providers; and
vii. A reference to the contractors' website for a complete listing of all its network providers.

c. Contain the ADHS/CRSA Notice of Privacy Practices (English and Spanish versions);
d. Be printed in a type, style, and size that can be easily read by recipients with varying degrees of visual impairment and meet the ADA regulations;
e. Be written at a level that is easily understood;
f. Have a date of the last update of the materials included;
g. Provide written notification that alternate formats are available and how to access them;
h. Provide written notification that oral interpreter services are available free of charge upon request; and inform potential enrollees and members on how to access those services;
i. Contain information on the following:
i. The Contractors' CRS Parent Action Council;
ii. Family and parent organizations and other appropriate resources including community service agencies.

3. CRS Contractors must, on an annual basis, inform all members of their right to request at a minimum:
a. An updated CRS Member Handbook; and
b. An updated comprehensive directory of the CRS Contractors' Clinic Providers.

D. Contractor Web site Content

1. The Contractor must include the following member related information on its website in a manner that members can easily find and navigate:
a. A current member handbook
b. Information about the PAC and any current newsletters prepared by the PAC
c. Formulary information available in a user-friendly format to include:
i. A medication formulary listing the brand name and/or generic, including notations for all medications requiring prior authorization
ii. A medication formulary listing by drug class
iii. A specific (individual) drug look-up capability
d. A user-friendly, searchable provider directory that includes the following search functions and is updated at least monthly, if necessary:
i. Provider name
ii. Specialty/service
iii. Languages spoken by the practitioner
iv. Clinic locations, including address, telephone number, and directions
e. Community resource information applicable to the CRS Contractors' population and geographic service area. Examples should include but

not be limited to WIC, Head Start, and AzEIP. The following links must be provided:
i. www.myazhealthandwellness.com,
ii. www.MyAHCCCS.com,
iii. www.az211.gov.

f. Services for which prior authorization is required and prior authorization criteria.
g. Best practice guidelines.
h. Tobacco cessation information and a link to the Tobacco Education and Prevention Program (TEPP) Web site

2. Any information that is not listed above, that is directly related to members or potential members must receive prior approval by CRSA.
3. CRSA will review the content of the Contractor's website to ensure the Contractor is in compliance with this policy and the CRSA contract

E. Potential Member Information/Freedom of Choice Brochure

1. The Contractor shall have summary information about its network available for distribution to *potential* members. The information must be updated at least quarterly.
2. The information will contain at a minimum:
   a. Providers including primary care, specialty, hospitals and pharmacy providers, telephone numbers, and non-English languages spoken by providers.
   b. A toll free telephone number that the potential member may call for additional information.

Section 1.3 Acronyms

"AAP" The American Academy of Pediatrics.

"ADA" The Americans with Disabilities Act Public Law 101-336 enacted July 26, 1990.

"ADE" The Arizona Department of Education.

"ADES" The Arizona Department of Economic Security.

"ADHS" The Arizona Department of Health Services, a State agency as defined in A.R.S. Title 36, Chapter 1. Pursuant to A.R.S. Title 36, Chapter 4.

"AHCCCS" The Arizona Health Care Cost Containment System, a State agency, as described in A.R.S. Title 36, Chapter 29, which is designated as Arizonaôs Medicaid program.

"AHCCCSA" The Arizona Health Care Cost Containment System Administration.

"ALTCS" The Arizona Long Term Care System, a program in AHCCCS that delivers long term, acute, behavioral health care and case management services to eligible members, as authorized by ARS 36-2931 et. seq.

"AMPM" The *AHCCCS Medical Policy Manual.*

"A.R.S." Arizona Revised Statutes.

"A.A.C" Arizona Administrative Code**:** the state regulations established pursuant to relevant statutes. Relevant sections of the AAC are referred to throughout this document as ñADHS Rulesò

"BIA" The Bureau of Indian Affairs.

"CDT" Current Dental Terminology.

"CMS" The Centers for Medicare & Medicaid Services, formerly the Health Care Financing Administration (HCFA).

"COBRA" The Consolidated Omnibus Budget Reconciliation Act.

"CY" Contract year, corresponds to state fiscal year (July 1 through June 30).

"CAP" Corrective action plan.

"CMS" Centers for Medicare and Medicaid Services.

"CPM" Clinical Performance Measure.

"CPT" Current Procedural Terminology.

"CRS" Children's Rehabilitative Services.

"CRSA" Children's Rehabilitative Services Administration.

"CYE" Contract Year Ended.

"DD" Developmental Disability/Developmental Delay.

"DES" The Arizona Department of Economic Security.

"DES/CMDP" The Comprehensive Medical and Dental Program in the Department of Economic Security, Division of Children, Youth and Families, through which the State provides health care to foster children.

"DES/DDD" The Division of Developmental Disabilities in the Department of Economic Security.

"DES/FAA" The Financial Assistance Agency within the Department of Economic Security.

"DUA" Data Use Agreement.

"DME" Durable medical equipment.

"EI" Early Intervention.

"FCC" Family centered care.

"FFP" Federal financial participation.

"HIPAA" Health Information Portability and Accountability Act.

"ICD-9" International Classification of Diseases-9th revision.

"I.D.E.A." Individuals with Disabilities Education Act.

"LEA" Local Education Agency.

"LEP" Limited English proficiency.

"I.E.P." Individualized Education Plan.

"I.F.S.P." Individualized Family Service Plan.

"ILC" Independent Living Center.

"JCAHO" The Joint Commission on the Accreditation of Healthcare Organizations.

"MED" Medical expense deduction.

"MM" Medical Management.

"NCQA" National Committee for Quality Assurance.

"OCR" Office of Civil Rights.

"PAC" Parent Action Council.

"PET" Positron Emission Tomography.

"PIP" Performance Improvement Project**.**

"PHI" Protected Health Information.

"PCP" Primary Care Provider**.**

"PA" Prior Authorization**.**

"PSR" Provider Services Requisition.

"QI" Quality Improvement.

"QMòQuality Management.

"QMP" Quality Management Plan.

"QOC" Quality of Care.

"UM" Utilization Management.

"SEA" State Education Agency.

"S.O.B.R.A." The Sixth Omnibus Reconciliation Act, 1986 Section 9401, as amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C., 1396a(a) (10)(A)ii(IX), July 1, 1988.

"SSA" Social Security Administration.

"SSI" Supplemental Security Income.

"SPAC" State Parent Action Council**.**

"TBI" Traumatic Brain Injury.

"TDD" Telecommunications Device for the Deaf.

Section 1.4

Definition of Terms
In this policy and procedure manual, unless otherwise specified:

"Abuse" Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the CRS program, or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the CRS program.

"Access to Care" A membersôattainment of timely and appropriate health care services.

"Action" The denial or limited authorization of a requested service including:

1. The type or level of service;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide a service in a timely manner, as set forth in contract; or
5. The failure of a contractor to act within the time frames specified by rule.
6. Denial of a rural CRS memberôs request to obtain services outside the CRS Contractorôs network under 42 CFR 438.52(b)(2)(ii), when the CRS Contractor is the only Contractor in the rural area.

"Acute Health Care" Medically necessary ambulatory, emergency, inpatient, and follow-up health services provided in response to the various stages of disease or injury.

"Administrative Hearing" A hearing under A.R.S. Title 41, Chapter 6, Article 10 (also called State Fair Hearing).

"Advance Directives" Documents written in advance that state your choices for health care, or name someone to make choices about your care if you are unable to make decisions.

"AHCCCS Medical Policy Manual (AMPM)" The AMPM provides information regarding covered health care services for Arizona residents who are eligible for AHCCCS acute and long term care services.

"Ambulation Assistive Devices" Means walkers, canes, and crutches.

"Americans with Disabilities Act (ADA)" A Public Law 101-336 enacted July 26, 1990. The ADA prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, state and local government services, public accommodations, commercial facilities, and transportation.

"Appeal" A request for review of an action.

"Appeal Resolution" The written determination by the CRS Contractor concerning an appeal.

"Applicant" An individual who has requested enrollment into the CRS program and for which CRS has received a written, signed, and dated application.

"Application packet" The completed documents, forms, and supplemental information necessary to process eligibility for CRS.

"Arizona Administrative Code (AAC)" State regulations established pursuant to relevant statutes. Relevant sections of the AAC are referred to throughout this document as "ADHS Rules".

"Arizona Department of Health Services (ADHS)" A State agency as defined in A.R.S. Title 36, Chapter 1. Pursuant to A.R.S. Title 36, Chapter 4, ADHS is responsible for licensure and certification (when applicable) of health care facilities included as AHCCCS-registered providers.

"Arizona Health Care Cost Containment System (AHCCCS)" AHCCCS is a state agency that oversees the Medicaid (Title XIX) and KidsCare (Title XXI) programs.

"Arizona Long Term Care System (ALTCS)" A program in AHCCCS that delivers long term, acute, and behavioral health care and case management services to eligible members, as authorized by ARS 36-2931 et. seq.

"Assess or Evaluate" The process used to examine and determine the level of quality or the progress toward improvement of quality and/or performance related to CRS Contractor service delivery systems.

"Authorization request (expedited)" Under 42 CFR 438.210, means a request for which a provider indicates or a CRS Contractor determines that using the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. The CRS Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires no later than three working days following the receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the CRS Contractor justifies a need for additional information and the delay is in the member's best interest.

"Authorization request (standard)" Under 42 CFR 438.210, means a request for which a CRS Contractor must provide a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the CRS Contractor justifies a need for additional information and the delay is in the member's best interest.

"Balanced Budget Act (BBA)" of 1997, Public Law 105-33, means the Federal law that increased the attention given to performance monitoring and quality assurance in both Medicaid and the newly created State Children's Health Insurance Program.

"Business day" Monday, Tuesday, Wednesday, Thursday, or Friday unless: a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday; or a legal holiday falls on Saturday or Sunday and a contractor is closed for business the prior Friday or following Monday.

"Capitation" Payment of a fixed monthly payment per person in advance for which the CRS Contractor provides covered services.

"Case Manager" A designated individual who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary health care.

"Children's Rehabilitative Services Administration (CRSA)" A subdivision of the ADHS, which provides regulatory oversight of the CRS Program and the contract processes as they relate to CRS Contractors and the delivery of health care services.

"Children's Rehabilitative Services (CRS)" A program that provides for medical treatment, rehabilitation, and related support services to eligible individuals who have certain medical, handicapping, or potentially handicapping conditions, which have the potential for functional improvement through medical, surgical, or therapy modalities.

"Claim Dispute" A contested payment of a claim, denial of a claim, or imposition of a sanction.

"CLAS" Standards for culturally and linguistically appropriate services in health care assuring cultural competence in health care.

"Clean Claim" A claim that may be processed without obtaining additional information from the provider of service or from a third party; but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

"Co-Insurance" Co-Insurance (coinsurance) a cost-sharing arrangement under a health insurance policy that provides that the insured will assume a portion or percentage of the costs of covered services. Health care cost which the covered person is responsible for paying, according to a fixed percentage or amount.

"Co-Payment" A cost-sharing arrangement in which the insured pays a specified flat amount for a specific service (such as $10 for an office visit or $5 for each prescription drug).

"Completion/Implementation Timeframe" The date or time period projected for a project goal or objective to be met, for progress to be demonstrated or for a proven intervention to be established as the standard of care for the CRS Contractor.

"Concurrent Review" The process of reviewing an institutional stay at admission and throughout the stay to determine medical necessity for an institutional level of care.

"Contract Year (CY)" The time corresponds to state fiscal year (July 1 through June 30).

"Coordination of Care" The process that links children and youth with special health care needs and their families to services and resources in a coordinated effort to maximize the potential of the children and provide them with optimal health care.

"Co-payment" An amount that the member pays directly to a provider at the time covered services are rendered.

"Corrective Action Plan (CAP)" A written work plan that includes goals and objectives, steps to be taken and methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timeframes. CAPs are generally used to improve performance of the CRS Contractor and/or its providers, to enhance activities and the outcomes of the activities, or to resolve a deficiency.

"Covered Services" A list of identified health medical services (refer to Chapter 40).

"CRSA Medical Director" The physician designated by CRSA to oversee the medical management portion of the CRS program. The Medical Director reports to the Office for Children with Special Health Care Needs (OCSHCN) Office Chief.

"CRS Clinic" An established, multi-specialty, interdisciplinary facility that provides CRS services to members.

"CRS Condition" A disease or disorder that qualifies for CRS coverage as identified in Chapter 30.

"CRS Credentialed Provider" The CRS Contractors are credentialed as approved by hospital standards.

"CRS Member" An individual who meets CRS eligibility requirements and is enrolled in CRS.

"CRS Provider" A CRS Contractor or its subcontractor who provide CRS covered services to a member.

"CRS Clinic" A multi-specialty interdisciplinary facility that provides CRS services to members.

"CRS Contractor" An entity contracted with CRSA under a capitation arrangement to provide CRS covered services directly or through sub-contractors to CRS members within a specific region of the state or through application of the CRS transfer policy.

"CRS Medical Director" The physician appointed by the CRS Contractor to make medical decisions about the medical eligibility of applicants and the medical care provided to members assigned to the CRS Contractor. The Medical Director also may provide medical advice and counsel to CRSA and to the CRS Contractor and interface with medical directors of other agencies and health plans on care coordination issues.

"CRSA Medical Director" Means the physician designated by the ADHS Director to provide appropriate input on medical issues to the CRS Office Chief.

"Current Dental Terminology (CDT)" A medical code set of dental procedures, maintained and copyrighted by the American Dental Association (ADA), and adopted by the Secretary of HHS as the standard for reporting dental services on standard transactions.

"Current Procedural Terminology (CPT)" A standardized mechanism of reporting services using numeric codes as established and updated annually by the American Medical Association (AMA).

"Cultural and Linguistic Competency" Culturally and linguistically appropriate services CLS means standards to measure the ability of health care provider and health organizations to respond to the cultural and linguistic needs of the patient in health care settings.

"Culturally Appropriate" means having cultural sensitivity relative to specific ethnic groups, i.e., understanding their customs, taboos, religious practices, fears, etc., and consequently developing services based upon this awareness.

"Culture" An integrated pattern of human behavior that includes thoughts, communications, languages, practices, beliefs, values, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of a racial, ethnic, religious or social group; the ability to transmit the above to succeeding generations; is dynamic in nature.

"Data Set" An organized collection of data. For example, the New Member Enrollment Log or Quality of Care Cases.

"Days" Calendar days unless otherwise specified in the text.

"DES/CMDP" The Comprehensive Medical and Dental Program in the Department of Economic Security, Division of Children, Youth and Families, through which the State provides health care to foster children. CMDP is an AHCCCS Health Plan.

"Deductibles" Amounts required to be paid by the insured under a health insurance contract, before benefits become payable. Usually expressed in terms of an "annual" amount.

"Diagnosis" A determination or identification of a disease or condition that is confirmed by a physician.

"Discharge Planning from CRS Program" Means healthcare planning that begins upon member enrollment and is coordinated through the interdisciplinary team approach to ensure a smooth transaction for the members from CRS care to other agencies or facilities.

"Discharge Planning from Inpatient Facility" A procedure where aftercare services are determined for after discharge from the inpatient facility. Required by Medicare and JCAHO for all hospital patients.

"Disease Management" An integrated approach to health care delivery that seeks to improve health outcomes and reduce health care costs by:

1. Identifying and proactively monitoring high-risk populations
2. Assisting members and providers in adhering to identified evidence-based guidelines

3. Promoting care coordination
4. Increasing member self-management, and
5. Optimizing member safety.

"Division of Developmental Disabilities" means the Department of Economic Security (DES) that provides services throughout the State of Arizona through institutional and community-based programs to members and adults who are developmentally disabled. DES/DDD is an AHCCCS Program Contractor for ALTCS.

"Dual Eligible" An individual who receives both Medicare and Medicaid benefits. Dually eligible people with disabilities usually receive Social Security and Medicare benefits and Supplemental Security Income (SSI) and Medicaid benefits. (The Social Security benefits are usually Disability Insurance benefits or Disabled Adult Child benefits received due to the retirement, death, or disability of a parent).

"Durable Medical Equipment (DME)" Adaptive aids and devices, adaptive wheelchairs and ambulation assistive devices.

"Durable Medical Equipment (DME), Customized" Equipment that has been altered or built to specifications unique to a member's medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.

"Eligible" An individual that has met all applicable criteria (age, residency, citizenship and medical) to be enrolled in CRS.

"Emergency Medical Condition" A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b) serious impairment to bodily functions; and/or c) serious dysfunction of any bodily organ or part.

"Emergency Services" Covered inpatient or outpatient services that are: a) given by a provider that is qualified to provide these services under this title; or b) needed to evaluate or stabilize an emergency medical condition.

"Employee" All officers and employees of the Department and of any local health department, including those who may be loaned or assigned to the Department or local health departments by another governmental or private health agency, including consultants paid on a fee basis by the Department or a local health department.

"Encounter" A record of a covered service rendered by a provider to a person enrolled with a capitated CRS Site on the date of service.

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"Encounter Data" Data relating to treatment or service rendered by a provider to a patient, regardless of whether the provider was reimbursed on a capitated or fee-for-service basis. Used in determining the level of service.

"Enrolled" An enrolled member is an individual who has been determined eligible and has been granted entry to the CRS program.

"Enrollment" The process by which an eligible person becomes a member of the CRS program.

"Error Rate" The number of errors divided by the number of values reported.

"Ex-member" An individual who is no longer enrolled in the CRS Program.

ñ**Family-centered"** Care that recognizes and respects the pivotal role of the family in the lives of members. It supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the provision of services to the member.

"Federal Financial Participation (FFP)" The Federal matching rate that the Federal government makes to the Title XIX and Title XXI programs in the state of Arizona.

"Filed" The receipt date as established by a date stamp.

"Formulary" An approved list of pharmaceuticals for dispensing for CRS Eligible conditions.

"Fraud" The intentional deception or misrepresentation made by a person or persons with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

"Functional Status" A measure of an individual's ability to perform normal activities of life.

"Genetics" The studies of how particular traits are passed from parents to children. Identifiable genetic information receives the same level of protection as other health care information under the HIPAA Privacy Rule.

"Grievance" An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to:

1. The quality of care or services provided; and
2. Aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrolleeôs rights.

   Grievances do not include ñaction(s)ò as defined in Arizona Administrative Code Title 9, Chapter 34 (9 A.A.C. 34).

"Guardianship" A person authorized under state or other law to act on behalf of the member in making health-related decisions. Examples: a parent acting on behalf of an un-emancipated minor or a parent who has petitioned for guardianship for their 18-21 year old member.

"Handicapping" Physical impairments that limit one or more major life activity such as: caring for oneself; performing manual tasks; walking; seeing; hearing; speaking; breathing; learning; and working.

"Health Care Professional" Under 42 CFR 438.2, means a physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or

occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed certified social worker, registered respiratory therapist and certified respiratory therapist technician.

"Health Information Portability and Accountability Act (HIPPA)" of 1996, Title II Subtitle F published by the United States Department of Health and Human Services, the administrative simplification provisions and modifications thereof, and the Administrative Simplification Compliance Act of 2001.

"Health Plan" An organization, now referred to as an Acute Care Contractor, which contracts with the AHCCCS Administration to administer the provision of a comprehensive package of AHCCCS covered acute care services to enrolled AHCCCS members.

"Home Health Services" In accordance with R9-7-406, means the services provided by a home health agency that coordinates in-home intermittent services for curative and/or habilitative care. This includes home health aide services, licensed nurse services, medical supplies, equipment and appliances.

"Hospital" A health care institution licensed as a hospital, as defined in ARS § 36-2351.

"Independent Living Center (ILS)" Peer support and resources for transitioning youth with special needs.

"Inpatient" An individual who has been admitted at least overnight to a hospital for the purpose of receiving diagnostic, treatment, observation, or other CRS services.

"Interdisciplinary Team" Physician and non-physician professionals and family members who collaborate in planning, delivering, and evaluating health care services.

"KidsCare" Arizona Children's Health Insurance Program, funded through Title XXI of the Social Security Act and state funds, also referred to as Title XXI. The KidsCare Program offers comprehensive medical preventive and treatment services and a full array of behavioral health care services statewide to eligible children under the age of 19.

"Local Health Department" Any district,, county, or city health department or any combination thereof.

"Logic Check" A review of the data to look for logical inconsistencies. For example, an enrolling visit that occurs before the member was born.

"Medical Assistance" The Title XIX portion of the AHCCCS program, which also includes S.O.B.R.A.

"Medical Assistance Financial Screening Form" The AHCCCS document that identifies potential Title XIX eligibility.

"Medical Expense Deduction (MED)" A Medicaid eligibility category for a Title XIX Waiver member whose family income is more than 100% of the Federal Poverty Level (FPL) and has family medical expenses that reduce income to or below 40% of the FPL.

"Medical Foods" A metabolic formula or modified low protein foods that are produced or manufactured specifically for members with a qualifying metabolic disorder and that are not generally used by persons in the absence of a qualifying metabolic disorder.

"Medical Home" An approach to providing comprehensive health care. A medical home is defined as care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.

"Medical Information" All clinical records, medical reports, laboratory statements or reports, any file, film, record or report, or oral statement relating to diagnostic findings and treatment of patients, as well as information relating to contacts, suspects, and associates of communicable disease patients.

"Medical Management (MM)" An integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to end of life care).

"Medical Staff" All physicians and dentists employed by or under contract with CRS.

"Medically Necessary" As defined in A.A.C R9-22-101.B. means a medically necessary covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or prolong life.

"Member" An individual who is enrolled in the CRS program.

"Member Abuse" Any intentional or reckless infliction of physical harm, injury caused by a negligent act or omission, unreasonable confinement, emotional or sexual abuse, or sexual assault to a CRS enrolled member.

"Member Information Materials" Any materials given to the CRS Contractor's membership. This includes, but is not limited to: member handbooks, member newsletters, surveys, on hold messages, health related brochures/reminders, videos, form letter templates, and Web site content. It also includes the use of other mass communication technology such as e-mail and voice recorded information messages delivered to a member's phone.

"Methodology" The planned process, steps, activities or actions taken by a CRS Contractor to achieve a goal or objective, or to progress toward a positive outcome.

"Minor" An individual who is:

1. Under the age of 18 years;
2. Incompetent as determined by a court of competent jurisdiction; or
3. Incapable of giving consent for medical services due to a limitation in the individual's cognitive function as determined by a physician.

"Monitoring" The process of observing, evaluating, analyzing and conducting follow-up activities.

"Multi-specialty" The use of more than one specialty physician or dentist in the treatment of a member.

"Notice of Action" Written notification to the member/representative of an action that the CRS Contractor has taken or intends to take.

"Notice of Appeal Resolution" Written notification to the member/ representative and other parties of the decision made by the CRS Contractor of an appeal.

"Notice of Decision" Written notification to the provider and other applicable parties of the decision made by the CRS Contractor regarding a claims dispute.

"Notice of Denial" Written notice to the applicant/representative of the decision of the CRS Program to deny enrollment.

"Notice of Eligibility Decision" Written notification to the member/ representative and other parties of the decision made by the CRS Contractor of an eligibility decision.

"Notice of Hearing Request" Written notification to the CRS Contractor that a member/representative or provider has requested an Administrative Hearing.

"Objective" A measurable step, generally in a series of progressive steps, to achieve a goal.

"Office of Civil Rights (OCR)" The office is part of HHS. Its HIPPA responsibilities include oversight of the privacy requirements

"Out of Network" Care provided by health care providers that are not a part of the CRS Contractor provider network.

"Out of Network Referral" A provisionally covered benefit that requires prior authorization by CRS Contractors for referrals to providers or facilities that are not in the network to satisfy unique health care needs of a CRS member.

"Outcome" A defined outcome that is the result of an intervention.

"Outcome Measurement" System used to track interventions and resulting outcomes.

"Outpatient Services" Health care services rendered to members who are not hospitalized.

"Outreach Clinic" A clinic designed to provide a limited specific set of services including evaluation, monitoring, and treatment in settings geographically closer to the member and their family than a CRS Clinic.

"Parent" A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction.

"Parent Action Council (PAC)" The regional council consisting of family members, parents, or legal guardians of children, who are, or have been, CRS members, or adults who are or were members. The Parent Action Council also includes professionals, advocacy groups, CRS Contractor representatives, and ADHS/CRSA staff.

"Payment Responsibility" The portion of the cost of CRS services that a member or family has agreed to pay, according to a signed Payment Agreement.

"Pediatric Transition to Adulthood" All youth with special health care needs receive the services they need to make necessary transitions to all aspects of adult life, including adult health care, work and independence.

"Peer Review" The review and evaluation of a practitioner's professional actions related to care of CRS members, by a selected peer group.

"Performance Measurement" Defining a target goal and measuring the effectiveness of interventions on a projected outcome

"Physician" An individual currently licensed as an allopathic or osteopathic physician under A.R.S. Title 32, Chapter 13 or Chapter 17.

"Plan-Do-Study-Act (PDSA) Cycle" means a scientific method for testing a change or intervention, designed to result in improvement in a specific area. The cycle is completed by planning the change/intervention, trying it, observing the results, and acting on what is learned. When these steps are conducted over a relatively short time period; i.e., over days, weeks, or months, the approach is known as Rapid Cycle Improvement.

"Post Stabilization Care Services" Medically necessary services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition or to improve the member's condition.

"Practice Guidelines" The description of medical practices that assist clinicians in making appropriate decisions regarding health care.

"Primary Health Care" Routine health care provided to prevent disease, treat injury or maintain general health.

"Primary Care Provider (PCP)" Any physician, physician assistant, or nurse practitioner coordinating acute and chronic health care for medical conditions, including those conditions that are not CRS conditions.

"Privacy" For purposes of the HIPAA Privacy Rule, an individual's interest in limiting who has access to personal health care information.

"Prior Authorization (PA)" The process by which a CRS Contractor determines in advance whether a service is medically necessary... Prior authorization is not a guarantee of payment.

"Protected Health Information (PHI)" Under HIPAA, this refers to individually identifiable health information transmitted or maintained in any form.

"Privacy Notice" The CRS Contractor must give notice describing practices regarding protected health information. The CRS members must obtain signed acknowledgements of receipt (also known as notice of privacy practices).

"Provider" A person or entity that subcontracts with a CRS Contractor to provide CRS covered services directly to members.

"Provider Network" A person or entity who agrees to the terms specified in the contract with the CRS Contractor.

"Provider Profiling" Information aggregated to the provider level.

"Provider Services Requisition (PSR)" A request from a health care provider to a CRS Contractor for prior authorizing a service.

"Quality Improvement (QI)" The systematic application to assess and improve internal operations.

"Quality Management (QM)" The review of the quality of health care provided to CRS members.

"Qualified" An individual meets the conditions, criteria, or requirements for enrollment in the CRS Program.

"Quality of Care Concern" There is possibility that an action could negatively impact the member's health care status.

"Range Check" A review of the data to look for values that are out of range. For example, an out of range value for a field that is defined as "yes" or "no" would be any value other than "yes" or "no"

"Rehabilitation Act of 1973" First major legislative effort to secure an equal playing field for individuals with disabilities. This legislation provides a wide range of services for persons with physical and mental impairments. The Rehabilitation Services Administration (RSA) administers the Act. Two Sections have immense regulatory impact on accessible Web design. These are Section 504 and 508. Section 504 of the Rehabilitation Act - Nondiscrimination Under Federal Grants and Programs.

"Reinsurance" A method of limiting the financial risk of providing services by purchasing insurance that becomes effective after set dollar amount has been reached.

"Reliability" The degree to which the measure is free from random error and the results are reproducible.

"Residence" The place where an individual lives.

"Resident" An individual who is living in Arizona and can provide proof of residency.

"Retrospective Review" The process of determining the medical necessity of a treatment/service post delivery of care.

"Sanction" Reprimand that for breaking a law or rule resulting in financial penalties.

"School" Any public or private institution offering instruction to students of any age.

"Scope of Service" The medical services covered under the CRS Program.

"S.O.B.R.A." The Sixth Omnibus Reconciliation Act, 1986 Section 9401, as amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C., 1396a(a) (10)(A)ii(IX), July 1, 1988. This program provides Medical Assistance to eligible pregnant women as soon as possible following verification of pregnancy, and provides Medical Assistance to as many eligible children born on or after October 1, 1988, as is possible.

"Special Health Care Needs" Serious congenital or chronic physical, developmental, or behavioral conditions that require medically necessary health and related services of a type or amount beyond that required by children generally. All CRS members are considered to be members with special health care needs.

"Specialty Care" Health care that requires specific professional education, knowledge, and skills to be delivered.

"Specialty Physician" A physician who is specially trained in a certain branch of medicine related to specific services or procedures, certain age categories of patients, certain body systems, or certain types of diseases.

"Social Security Administration (SSA)" The Federal agency that administers SSI, SSDI, and related programs.

"Supplemental Security Income (SSI)" The Federal income supplement program funded by general tax revenues (not Social Security taxes). It is designed to help aged, blind, and disabled people, who have little or no income; and it provides cash to meet basic needs for food, clothing, and shelter.

"State, the" The State of Arizona.

"State Parent Action Council (SPAC)" The state council consisting of family members, parents, or legal guardians of a child who is, or has been, a CRS member, or adults who are or were members. The SPAC includes professionals, advocacy groups, Contractor representatives, and CRSA staff.

"Telehealth" The use of telecommunications (i.e., wire, internet, radio, optical or electromagnetic channels transmitting text, x-ray, images, records, voice, data or video) to facilitate medical diagnosis, patient care, patient education, and/or health care/medical learning (member not present).

"Telemedicine" The delivery of diagnostic, consultation and treatment services that occur in the physical presence of the member on a real time basis through interactive audio, video and

data communications, as well as the transfer of medical data on a store and forward basis for diagnostic or treatment consultations.

"Termination Date" The date that a member is no longer eligible for services.

"Timely Appointment" An appointment timeframe that, if not met, may adversely affect the health of an enrolled member.

"Title V" The federal statutes governing the Maternal and Child Health Program, which is a public health service of the U.S. Department of Health and Human Services.

"Title XIX" The Federal Medicaid Program, Title XIX of the Social Security Act provides for Federal grants to the states for medical assistance programs. Title XIX enables states to furnish medical assistance to those who have insufficient income and resources to meet the costs of necessary medical services, rehabilitation and other services to help those families and individuals become or remain independent and able to care for themselves.

"Title XXI" The State Children's Health Insurance Program (SCHIP), Title XXI of the Social Security Act provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low income children in an effective and efficient manner that is coordinated with other sources of child health benefits coverage. In Arizona, the SCHIP program is known as KidsCare.

"Tracking of Disclosures" he HIPAA Privacy Rule gives individuals the right to request an accounting of disclosures of protected health information over the previous six years.

"Treatment Plan" A written plan of services and therapeutic interventions based on a comprehensive assessment of a member's developmental and health status, strengths, and needs that are designed and periodically updated by the interdisciplinary team.

"Trending" The method of estimating needs and costs of health services by reviewing past trends in cost and utilization of these services. Trending also means analysis of data to identify potential issues.

"Utilization Management/Review" The CRSA and the CRS Contractor's process to evaluate appropriateness, efficacy and efficiency of medically necessary services.

"Youth" An individual over the age of 14 years, but less than 21 years of age.

Section 2.1 CRS Mission & Organization

A. Mission

The mission of Arizona Children's Rehabilitative Services (CRS) is to improve the quality of life for children by providing family-centered medical treatment, rehabilitation, and related support services to enrolled individuals who have certain medical, handicapping, or potentially handicapping conditions.

B. Goal

The goal of the CRS program is to provide quality care through early detection, prevention, comprehensive medical treatment, and rehabilitation to enrolled individuals with handicapping or potentially handicapping conditions.

C. Objective

The objective of CRS is to assure the highest quality comprehensive care for the functional improvement of medically qualified individuals through a family-centered, multi-specialty, interdisciplinary team approach in a cost-effective managed care setting.

D. Program Description and Organization

1. Program Description

   CRS serves individuals under 21 years of age residing in Arizona who meet the criteria established by CRSA. A combination of funding is received from state and federal sources. CRSA receives federal funding from the Arizona Health Care Cost Containment System Administration (AHCCCSA) for Title XIX eligible AHCCCS members and for Title XXI eligible members who are enrolled in the State Children's Health Insurance Program known as KidsCare. CRSA also receives funding through the Title V Maternal and Child Health Block Grant.

   CRS provides medical treatment, rehabilitation, and related support services to individuals who have certain medical, handicapping, or potentially handicapping conditions, which have the potential for functional improvement through medical, surgical, or therapy modalities. CRS provides these services through service contracts, where the approach to service delivery is family-centered, coordinated, culturally effective, and considers the unique needs of eligible persons. CRS is not a primary care provider. Each individual is expected to have a primary care provider from which to receive primary health care. The CRS clinic may provide a list of resources to individuals or families who do not have a primary care provider.

2. Program Organization

   The Bureau for Maternal and Child Health is responsible for CRS at the federal level. This bureau is in the Public Health Services of the U.S. Department of Health and Human Services (PHS/DHHS), which oversees the Arizona Department of Health Services (ADHS). ADHS is responsible for the administration of the CRS Program as stated in Article 3, A.R.S. § 36-261.

ADHS coordinates, as applicable, with other State agencies to fulfill this requirement.

At the State level, CRSA operates within the Office for Children with Special Health Care Needs (OCSHCN), within the Division of Behavioral Health Services within ADHS. ADHS is responsible for employing a CRSA Medical Director and an OCSHCN Administrator for CRSA who shall have duties and titles as fixed by the ADHS Director.

CRSA is responsible for: monitoring and evaluating services provided by private contractors; keeping statistical data on the CRS population; providing support and consultant services; and ensuring overall program management and planning.

CRSA solicits contracts from qualified offers to provide CRS services throughout the State of Arizona. These CRS Contractors are responsible for the administration and delivery of CRS services to CRS members statewide. CRS Contractors develop and maintain a provider network of specialty physicians, personnel, and facilities to meet the CRS minimum requirements. CRS Contractors may determine the appropriate reimbursement methods and amounts for their contracted provider network. CRSA oversees the performance of the CRS Contractors. The CRS Contractors are subject to contractual requirements and follow policies and procedures, administrative rules, and laws.

Section 2.2 Governing Statutes & Regulations

A. Federal

Title V, Part 2, of the Social Security Act (the Act) contains the general provisions setting up the powers and functions of the Social Security Administration, which may provide Title V federal funds to CRS. Part 2 makes provision for the appropriation and allocation of certain sums of money to the various states.

The Act requires that each state shall submit a plan for services for CRS individuals which will provide for financial participation by the State; administration of the plan by a state agency or supervision of the plan by a state agency; and appropriate methods of administration and reports. The Secretary of the Department of Health and Human Services must approve a state plan before federal subsidies can be provided to fund the CRS Program.

Funding will be denied should the Secretary of Health and Human Services find that the state operation of the CRS Program does not comply with the rules and regulations set forth by the Social Security Administration.

Title XIX of the Act establishes the Medicaid program, which is a national health care program providing Medical Assistance to families and to aged, blind and disabled individuals whose income and resources are insufficient to meet the cost of necessary medical services. The program is administered by the Centers for Medicare & Medicaid Services (CMS) of the federal Department of Health and Human Services (DHHS). Medicaid is a state/federal partnership under which the federal government establishes basic program rules. Each state must submit a State Plan describing how it will administer the Medicaid program within the confines of federal rules governing the program.

In Arizona, the Medicaid program is known as the Arizona Health Care Cost Containment System (AHCCCS). Federal Medicaid funding is available for all Medicaid-covered services rendered to enrolled CRS members who are federally eligible and enrolled in AHCCCS, in accordance with Arizona's Medicaid State Plan. Many children who are CRS members are concurrently enrolled in AHCCCS. The AHCCCS Administration also oversees the delivery of health care services funded by Title XXI, the State Children's Health Insurance Program. In Arizona, this program is known as KidsCare. Children who are medically qualified for CRS may also be enrolled in KidsCare. The CRS Administration works closely with the AHCCCS Administration to ensure CRS service delivery requirements are consistent with Medicaid and KidsCare requirements.

B. State

In accordance with the provisions of the Act, administration of the CRS Program in Arizona has been assigned by the Legislature to the ADHS.

Enabling legislation for CRS is found in Article 3, A.R.S. §§ 36-261 and 36-265. Enabling legislation for the care, treatment and reimbursement to the Department for individuals

with sickle cell anemia is set forth in Article 13, A.R.S. §§36-797.43 and .44, respectively.

The adopted Rules for CRS are set forth in A.A.C., Title 9, Chapter 7, Articles 1 through 7.

Section 2.3 Program Qualification Overview

A. CRS Applicant Requirements

1. Any individual may be referred to CRS. To be considered for the CRS program the applicant must:
   a. Have a CRS medical condition as set forth in A.A.C., Title 9, Chapter 7, Article 2, Section 202;
   b. Meet the age requirement of less than 21 years of age;
   c. Meet residency requirements in the state of Arizona; and
   d. Provide documentation of legal residency in the United States.

2. Once these requirements are met, the amount of the member's payment responsibility is determined, based on the family's income and resources. Refer to Section 4.0 for eligibility and enrollment requirements.

3. To be enrolled in the program, a member of the CRS professional staff shall evaluate the individual in a CRS pediatric screening clinic or specialty clinic. The physician or designee determines/verifies if the individual has a disabling or potentially disabling condition that qualifies for treatment in the CRS program.

B. Program Services

CRS program services are set forth in A.A.C., Title 9, Chapter 7, Articles 4 and 5.. Specific policies relative to CRS covered services are presented in Section 6.0 of this manual.

C. CRS Providers

1. The licensure and certification requirements for CRS providers are as follows:
   a. Physicians and dentists must be licensed in the State of Arizona.
   b. Nurses must be licensed in the State of Arizona.
   c. Social Workers must be licensed in the State of Arizona and have three (3) years of pediatric experience.
   d. Audiologists must maintain a current Arizona Audiologist license. If non-certified or clinical fellowship year (CFY) personnel are utilized, they must be under the direct (onsite) supervision of an Arizona licensed audiologist.
   e. Speech-Language Pathologists must maintain a current Arizona Speech-Language Pathologist license.
   f. Orthotists and prosthetists must be certified by the American Board for Certification in Orthotics and Prosthetics.
   g. Hearing aid dispensers must be licensed in the State of Arizona.
   h. Pharmacists must be licensed in the State of Arizona.
   i. Psychologists must be licensed by the State of Arizona Board of Psychologist Examiners.
   j. Physical and occupational therapists must be licensed issued by the Arizona Board of Physical Therapy and the Arizona Board of Occupational Therapy, respectively.
   k. Other ancillary personnel must be licensed or certified if required by the

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Standards.

2. Any individually contracted specialist such as a physician, dentist, psychologist, etc. who provides services to individuals enrolled in federally funded programs must be an AHCCCS registered provider in addition to their licensing requirements.

3. Facilities providing CRS services shall be licensed by the ADHS and Medicare certified by CMS, and/or accredited by the JCAHO, Accreditation Association for Ambulatory Health Care (AAAHC), or other nationally recognized accrediting body within two (2) years of licensure.

Section 2.4 CRS Program Funding

A. Federal Participation in the CRS Program

Under Title V of the Social Security Act, Congress may annually appropriate funds for statesô programs for children with special needs. The federal law requires that out of this appropriation, the Secretary of the Department of Health and Human Services must allocate by statutory formula based on member of low income children and other factors a fixed amount to each state. A minimum of thirty percent mix allocation must be used for children with special health care needs. The State, in accepting these federal funds, agrees to conform with the details of the State Plan for the provision of CRS authorized services. The State Plan is approved by the Secretary of Health and Human Services (HHS), to conform with the federal regulations applicable to State Plans. As a condition of accepting federal funds, CRSA agrees to conform to all applicable federal regulations. The Secretary may also grant portions of the federal funds to individual special projects for the provision of specialized services to children.

Under Title XIX of the Act, federal funding is available for Medicaid-covered services provided to Title XIX categorically eligible individuals in the form of Federal Financial Participation (FFP). Each state has an established Federal Medical Assistance Percentage (FMAP) amount that is paid by DHHS for most Medicaid program expenditures, although that amount may be higher for certain types of expenditures.

In the State of Arizona, the AHCCCS Administration (AHCCCSA) has been designated as the single State agency to receive and distribute Title XIX and Title XXI funds. ADHS has an Interagency Service Agreement (ISA) with the AHCCCSA regarding the CRS programôs use of Title XIX funds for the treatment of CRS conditions. To receive federal reimbursement for CRS services, CRSA shall submit financial reports and encounter data for the provision of CRS authorized services to AHCCCS no later than thirty (30) days following each reporting period, as stipulated in the ISA between the AHCCCS Administration and ADHS. AHCCCS claims FFP from CMS and is required under the terms of its ISA with CRSA to pass through federal monies to CRS.

B. State Participation in the CRS Program

The State must participate in the financing of CRS according to the Social Security Act, Title V, Part 2, § 513. The amount of State money available for CRS is determined annually through the Appropriations Act. CRSA receives AHCCCS funds and non-AHCCCS funds as two separate appropriations for program support. CRS receives State dollars for the ñstate matchòneeded in order to claim FFP.

C. Family Participation in the CRS Program

Individuals/families shall participate in a financial interview with a CRS Contractorôs staff member to determine the individual/family's payment responsibility. The payment responsibility is determined by comparing the family adjusted gross income to the current Federal Poverty Level limit amounts for income and family size.

Members who do not have a payment responsibility include the following:

1. Wards of the State or of the Court;
2. DES/Comprehensive Medical and Dental Program (CMDP) foster children;

3. DES adoption subsidy children; or
4. Children who are Title XIX or Title XXI eligible.

See Payment Responsibility in Section 4.5 and A.A.C. R9-7-604.

Section 2.5 Statewide CRS Medical Directors'/Administrators' Meeting

A. Purpose

Meetings of the CRSA Medical Director and CRSA along with CRS ContractorsôMedical Directors and Administrators provide an ongoing mechanism for the development and review of CRS policies and procedures, as well as the discussion and resolution of other contractual, programmatic, or operational issues regarding the CRS program. The meetings offer a forum for CRSA to provide guidance and advice to CRS and to review and comment on issues having statewide impact on program operations. Each CRS contractor has an opportunity to propose items for discussion at the meetings.

B. Meetings

The CRS Medical Directors and Administrators shall meet with CRSA representatives no less than four (4) times per year. Additional meetings may be requested by any member of the team to address major CRS Program issues having a significant impact on the delivery of care and/or program operations.

C. Membership

The membership includes CRSA Administration, CRSA Medical Director, CRS Medical Directors, CRS Contractor Administrators, and parent representation from the Parent Action Council (PAC). The Medical Directorsô/Administratorsô Meeting includes the CRSA Administrator, CRSA Medical Director, CRS Contractor Medical Directors, Contractor Administrators, and parent representation from the PAC.

Section 3.1 Coordination of Care with State & Federal Agencies

It is the policy of the CRS Program to coordinate with other State and Federal agencies in the provision of services for CRS members.

A. Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS)

CRS members may be concurrently enrolled in the state behavioral health system. CRS Contractorsô staff coordinates treatment and services for members with staff at DBHS and with the Regional Behavioral Health Authorities (RBHA) and the Tribal Regional Behavioral Health Authorities (TRBHA).

B. AHCCCS Administration and AHCCCS Health Plans

CRS members may be concurrently enrolled in an AHCCCS acute care health plan or with an ALTCS Program Contractor, or the KidsCare Program (administered by AHCCCS) to receive acute or long-term care health services. CRS Contractorsô staff coordinate care for members with staff of AHCCCS plans and program contractors and other insurers as needed and appropriate.

The AHCCCS Administration is responsible for determining member eligibility for Title XXI and for the ALTCS program. CRS is subject to AHCCCS rules and policies as they apply to CRS members enrolled in Title XXI programs and the ALTCS program.

C. Arizona Department of Economic Security (DES)

The Arizona Department of Economic Security is responsible for determining member financial eligibility to federally funded programs such as Title XIX. CRS is subject to AHCCCS rules and policies as they apply to CRS members enrolled in Title XIX programs.

The CRS Program coordinates treatment and service delivery with other agencies such as Arizona Early Intervention Program (AzEIP) and the Department of Developmental Disabilities (DDD) for identification, diagnosis, and treatment.

D. Department of Education

ñState Educational Agency (SEA)ò is an organization governing every school district in each state and is autonomous with individual school districts, known as ñLocal Education Agency (LEA)ò The Local Education Agency is a public board of education or other public authority legally constituted within a State for either administrative control or direction of, or to perform a service function for, public elementary or secondary schools in a city, county, township, school district, or other political subdivision of a State, or for a combination of school districts or counties as are recognized in a State as an administrative agency for its public elementary or secondary schools. The Local Education Agency includes:

1. An educational service agency;
2. Any other public institution or agency having administrative control and direction of a public elementary or secondary school, including a public charter school that is established as an LEA under State law; and
3. An elementary or secondary school funded by the Bureau of Indian Affairs, not

subject to the jurisdiction of any SEA other than the Bureau of Indian Affairs, but only to the extent that the inclusion makes the school eligible for programs for which specific eligibility is not provided to the school in another provision of law and the school does not have a student population that is smaller than the student population of the LEA receiving assistance under this Act with the smallest student population.

E. Indian Health Services, Fee for Service

CRS Contractors may coordinate with the Indian Health Service (IHS) or tribal nations in the provision of CRS outreach clinics on Indian reservations to CRS members. CRS Contractorsô staff coordinates care for members with staff of IHS and contractors and other insurers as needed and appropriate. CRS is subject to IHS fee for service rules and policies as they apply to CRS members.

F. IHS AHCCCS

CRS Contractors may coordinate with Indian Health Services (IHS) or tribal nations in the provision of CRS outreach clinics on Indian reservations to CRS members. CRS Contractorsô staff coordinates care for members with staff of IHS and contractors and other insurers as needed and appropriate. CRS is subject to AHCCCS rules and policies as they apply to CRS members.

G. IHS Tribal Health Services

CRS Contractors may coordinate with Indian Health Services (IHS) or tribal nations in the provision of CRS outreach clinics on Indian reservations to CRS members. CRS Contractorsô staff coordinates care for members with staff of IHS and contractors and other insurers as needed and appropriate. CRS is subject to identified tribal entity rules and policies as they apply to CRS members.

Section 3.2 Services Provided Outside the State of Arizona

A. Out-of-State Services Requirements

Services provided outside the state of Arizona are covered for CRS members when all of the following are verified:

1. The out-of-state services are related to a CRS condition;
2. The medical specialty, treatment, or procedure is not available in Arizona;
3. Two CRS physicians of the appropriate medical specialty recommend out-of-state treatment;
4. The treatment is considered to be lifesaving and will result in significant functional improvement based on favorable data published in peer reviewed national medical literature;
5. Prior authorization is obtained from the CRS Medical Director and Administrator;

B. The procedures for obtaining out-of-state services are as follows:

1. The memberôs sub-specialist in the specialty for which the out-of-state service is needed must initiate the out-of-state service request which must include the following:
   a. The specific treatment requested;
   b. Documentation of the fact that the requested procedure is not available in Arizona and that the treatment is lifesaving or will result in significant functional improvement for the member; and
   c. The names of specific physicians and hospitals that have the necessary expertise to perform the procedure and must provide documentation of such expertise along with correspondence indicating the providersô willingness to perform the procedure for the member;
2. The memberôs requesting sub-specialist physician shall send the treatment request to the appropriate CRS Medical Director.
   a. The appropriate region to send an out-of-state treatment request is the CRS Contractor where the requested type of treatment would ordinarily take place for the member under current CRS policy. This site is responsible for coordination of arrangements for out-of-state care, and paying for that care.
   b. Before approving or denying a request, the CRS Medical Director must request a consultation from a sub-specialist in the same specialty area as the requesting physician, but from another CRS Contractor, to review the request.
   c. The CRS Medical Director has the authority and responsibility to approve or deny the request based on:
      i. Memberôs eligibility status.
      ii. Whether or not requested procedure is a covered service.
      iii. Adequacy of documentation submitted with the request.
3. If the CRS Medical Director denies the request, he/she must notify the requesting subspecialist of the denial and must include the grievance process (see Section 8.2).
4. If the CRS Medical Director approves the request, he/she forwards the request to the CRS Administrator.

a. The CRS Administrator is responsible for negotiating the arrangements and payment rates with the out-of-state providers.
b. A member shall comply with the payment responsibility provisions of Section 4.5 and R9-7-604 for covered services received from out-of-state providers.
c. Travel expenses and lodging are not covered.
d. The out-of-state treatment site must provide a discharge summary for the member.
e. Upon receipt of the required documentation, the CRS Administrator will authorize payment to the out-of-state providers.

5. The Medical Director is responsible for:
   a. Care coordination with the out-of-state provider
   b. Follow-up care for the member upon return to Arizona.

Section 3.3 Transition of Care

Members Aging Out of the CRS System

CRS Contractors shall have a system for transition of care for all members aging out of the CRS system to ensure compliance with continuity of care for all CRS members which includes the following:

A. The CRS Contractor shall notify the member's primary health care provider and the AHCCCS Contractor in writing ninety (90) days prior to the member's 21st birthday to ensure continuity of care. CRS is not financially responsible for an AHCCCS member on or after his/her 21st birthday.

B. CRS Contractors shall ensure that an ETI (Enrollment Transition Information) Form (AHCCCS Exhibit 520-2, available at http://www.ahcccs.state.az.us/Regulations/OSPpolicy/chap500/Chap500.pdf) is completed for all CRS enrolled members ninety (90) days prior to their 21st birthday and placed in the member's medical record;

C. CRS Contractors shall submit a monthly electronic ETI log (Excel Format) with the member's name, AHCCCS ID, Date of Birth, CRS diagnosis, name of legal guardian, AHCCCS Health Plan, member's PCP, date ETI was submitted to the Health Plan, and 90-day timeline met, including the copy of all ETI forms to the CRSA MM/UM Program on a monthly basis; and

D. The CRS Contractors compliance for continuity of care for member(s) aging out of the CRS system shall be evaluated monthly by a CRSA Utilization Management Specialist.

Section 4.1 Eligibility Requirements

A. CRS Eligibility Requirements

CRS serves individuals who meet the following requirements:

1. The individual is under 21 years of age;
   One of the following may be used as proof of age:
   a. A certified copy of a birth certificate;
   b. A certified copy of a religious record issued within three (3) months of birth;
   c. A naturalization certificate reflecting U.S. citizenship;
   d. A current or expired U.S. passport;
   e. A certificate of U.S. citizenship; or
   f. Date of birth in PMMIS.
2. The individual is a U.S. citizen or qualified alien;
   One or more of the following may be used as proof of citizenship/qualified alien:
   a. A certified copy of a birth certificate;
   b. A naturalization certificate reflecting U.S. citizenship;
   c. A current or expired U.S. passport;
   d. A certificate of U.S. citizenship;
   e. A document that verifies the applicant's status as a qualified alien [A.R.S. 36-2903.03(B)]; or
   f. Indication in PMMIS of prior or current Title XIX/XXI eligibility (except Federal Emergency Assistance, which is for undocumented individuals).
3. The individual is a resident of Arizona; and
   One of the following may be used as proof of residency:
   a. A rent or mortgage receipt for property located in Arizona where the applicant lives;
   b. A lease for property located in Arizona where the applicant lives;
   c. A written statement confirming residence at an Arizona nursing care institution under A.R.S., Title 36, Chapter 4, signed by the administrator of the Arizona nursing care institution;
   d. An unexpired Arizona motor vehicle operator's license;
   e. A current Arizona motor vehicle registration, issued within 12 months from the date of an application for enrollment in CRS;
   f. Pay stub from an Arizona employer;
   g. A utility bill for property in Arizona where the applicant lives;
   h. A current phone directory listing for a telephone located at property in Arizona;
   i. A United States Post Office record reflecting an Arizona residence;
   j. A certified copy of a school record reflecting an Arizona residence;
   k. If none of the documents in subsections (3.a.) through (3.k.) are available, and the applicant resides in Arizona, the applicant, or if the applicant is a minor, the applicant's parent or legal guardian, may sign an affidavit certifying the individual is currently an Arizona resident and intends to remain in Arizona; or
   l. An Arizona address as indicated in PMMIS.

4. The individual has a CRS eligible medical condition. CRS eligible medical conditions and excluded medical conditions are listed in CPPM Sections 5.1 and 5.2.

B. Adults With Cystic Fibrosis and Sickle Cell Anemia

The contractor may enroll an adult, who is not eligible for Title XIX health care insurance, in CRS if:

1. The adult has cystic fibrosis and monies are appropriated to the contractor through ADHS under A.R.S. § 36-143, or
2. The adult has sickle cell anemia and monies are appropriated to the contractor through ADHS under A.R.S. § 36-797.44.

Section 4.2 Referrals & Enrollment Into the CRS Program

A. Referrals to CRS

Referrals to CRS are initiated by submitting a CRS Referral Form. The CRS Referral Form can be obtained from many sources, including physiciansô offices, the ADHS/CRSA webpage (www.azdhs.gov/phs/ocshcn; click on CRS, and then click on CRS Referral Form in English or Spanish) and the CRS Contractor locations. The CRS Referral Form may be faxed, mailed, or delivered in person to a CRS Contractor.

1. The CRS Referral Form shall contain the following:
   a. The name, address, and phone number of the referral source;
   b. The relationship of the person completing the referral form to the applicant;
   c. The applicantôs name, date of birth, social security number, sex, home address and contact information, race, and preferred language;
   d. If the applicant is a child, the name of at least one parent/guardian of the applicant;
   e. If known to the referral source:
      i. The applicant's diagnosis;
      ii. The applicant's primary care physician or, if the applicant does not have a primary care physician, the name of a health care organization at which the applicant receives medical care;
      iii. Whether the applicant is enrolled in Title XIX or Title XXI or has other health insurance;
      iv. Whether the applicant is a U.S. citizen or qualified alien; and
      v. If a physician has not evaluated the applicant, the reason the referral source believes the applicant may be eligible for CRS.

2. Documentation to accompany the referral form:
   For applicants who have been evaluated by a physician:
   a. Documentation from a physician who has evaluated the applicant that supports the medical diagnosis;
   b. Diagnostic test results that support the medical diagnosis;

3. **Processing Referrals and Documentation**

Within fourteen (14) calendar days of receipt of a referral, the CRS Contractorôs Medical Director, or designee, must review the documentation provided to determine an applicantôs eligibility for CRS. The CRS Contractor should use the PMMIS system as verification of Title XIX/XXI enrollment, age, residency and citizenship/qualified alien status. For applicants who have never been enrolled in Title XIX/XXI, and therefore, have no information in PMMIS, the determination of eligibility can be made based on the information provided on the referral and verification will be requested later.

CRS Contractors shall follow the process below according to the eligibility determination made from reviewing the referral and documentation:

1. Eligible ï If the CRS Medical Director, or designee, determines that the applicant meets the CRS eligibility criteria:

a. Provide written notice to the applicant/family, the referral source, and the AHCCCS Health Plan, if applicable, indicating that the applicant is eligible for CRS.
b. Send AHCCCS enrolled members an Assignment of Benefits form (Attachment 1) for signature, which must be received prior to the provision of services.
c. Send non-AHCCCS enrolled applicants a financial application and request for any verifications needed. The requested form and verifications must be received and processed prior to enrollment in CRS.
d. Initiate a Service Plan indicating the first service the member should be provided and the date by which it must be provided. (See Section 11.14 for information on the Service Plan)

2. Not Eligible ï If the CRS Medical Director, or designee, determines that the applicant does not meet the CRS program eligibility requirements:
   a. Provide written notice to the applicant/family and the referral source indicating that the applicant is not eligible for CRS and the reason for the denial within ten (10) days of the determination of ineligibility for CRS;
   b. Provide notification of the applicantôs right to appeal compliant with A.R.S. 41-1092.03;
   c. Provide written notice to the AHCCCS Health Plan, if applicable, indicating that the applicant is not eligible for CRS and the reason for the denial within five (5) days of the determination of ineligibility for CRS.

3. Need More Information ï If the Medical Director, or designee, is unable to determine CRS eligibility based on the documentation provided, a notice requesting the missing information within thirty (30) days shall be sent to the applicant and referral source. If no further documentation is received within ninety (90) days, the application will be considered withdrawn.

4. Further Diagnostic Testing or Initial Medical Evaluation ï
   a. Further Diagnostic Testing ï If the Medical Director, or designee, determines that further diagnostic testing is required to determine if the applicant has a CRS medical condition, the CRS Contractor shall:
      i. If the applicant is not enrolled in Title XIX/Title XXI and does not have other insurance that will cover the diagnostic testing, conduct a financial calculation to determine the member payment responsibility. Ensure that the applicant/family understands the payment responsibility prior to conducting any diagnostic tests and that the application/family signs a member payment agreement form. If the applicant/family does not sign a member payment agreement form, the CRS Contractor shall inform the applicant/family that the diagnostic testing cannot be ordered and the application will be considered withdrawn.
      ii. If the applicant has Title XIX/Title XXI or other insurance that covers the diagnostic testing, the CRS Contractor shall:

1) Request that the applicant have the diagnostic testing completed through the AHCCCS Health Plan or other insurance and have the results sent to the CRS Contractor;
2) Assist the applicant by working with the applicant's insurance company to obtain prior authorization of services, billing and collection from the third party payer and to obtain the diagnostic results; and
3) Within fourteen (14) calendar days of receipt of the diagnostic test results, make a determination of eligibility.

b. Initial Medical Evaluation ï If the Medical Director, or designee, needs to see the applicant for an initial medical evaluation, a notice must be sent to the applicant/family stating that an initial medical evaluation is necessary to determine if the applicant has a CRS medical condition. The notice must:
   i. Indicate a scheduled appointment date and time for the initial medical evaluation within thirty (30) days of the notice; and
   ii. Inform that if the applicant does not show for an initial medical evaluation within ninety (90) days, the CRS application will be considered withdrawn; and
   iii. Include an Assignment of Benefits form to be signed prior to providing any services if the applicant is a Title XIX/Title XXI enrolled member; or
   iv. Include a CRS financial application form to be completed if the applicant is not a Title XIX/Title XXI enrolled member.

C. Enrollment

1. For Title XIX/XXI enrolled applicants, the Contractor shall enroll the applicant in CRS effective on the same date as the eligibility determination.
2. For non-Title XIX/XXI enrolled applicants, the Contractor shall enroll in CRS upon completion of the following:
   a. Financial screening for potential AHCCCS eligibility, cooperation with the AHCCCS application process if found to be potentially eligible, financial calculation to determine member payment responsibility, and receipt of a signed Member Payment Agreement form (see Section 4.3); or
   b. Receipt of a signed Member Payment Agreement form agreeing to pay 100% for the cost of CRS services.

D. Referral Management

The CRS Contractor will have a policy and procedure for referral of members with specialized care. Examples of referrals include: out-of-state referrals, second opinions, referrals from one CRS clinic specialist to another, health plan referrals, and referrals from primary care providers to CRS clinics.

Attachment 1

Arizona Department of Health Services/ Office for Children with Special Health Care Needs
Children's Rehabilitative Services

ASSIGNMENT OF BENEFITS AGREEMENT FOR AHCCCS/KIDSCARE MEMBERS

Patient Name_____
D.O.B._____

Does patient have Medical Insurance? Yes ☐ No ☐

I agree that any moneys received by me as a court award or settlement of a claim which provides for medical care of the member shall be used to pay CRS providers for care which is authorized and provided. I agree that when insurance benefits, court awards, claim settlements or other third party benefits are available, I shall make them available before CRS funds shall be used to provide care for the member or shall be used to reimburse CRS or the CRS contractor for all care provided to the member. If I receive and convert any benefits described by this subsection to my personal use and not for payment of the memberôs CRS services, I shall be personally responsible for the payment of the services for which the benefits were intended to pay.

I agree to provide all information necessary to enable CRS and CRS providers to collect such insurance. I agree to notify CRS within ten (10) days of any financial or insurance changes that would affect my financial eligibility.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize CRS to release information necessary for the completion of hospital, other providers, and medical insurance claims. I also authorize CRS to exchange information with DES or AHCCCS and other insurance companies as necessary to determine financial eligibility.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize any insurance company with whom I have coverage, to make payment directly to the hospital, clinic, physician or other CRS provider rendering service. I also agree to forward any insurance moneys, received for services rendered through Childrenôs Rehabilitative Services, to the provider of such service. I agree to send copies of all explanation of benefits received by me from my health insurance company to CRS or CRS providers.

I certify that I have read this agreement, received a copy, and am authorized to act for the member and as his or her parent to execute and accept the terms, conditions and authorizations set out above.

Expiration Date _____

Financially Responsible Person_____ Date _____

CRS Financial Staff _____ Date of Agreement_____

Effective: 11/02/06

Section 4.3 Title XIX/Title XXI Screening and CRS Financial Application

A. Title XIX/XXI Screening

A CRS applicant not enrolled in Title XIX/XXI must cooperate in screening for potential Title XIX/XXI eligibility, must apply for Title XIX or XXI if determined potentially eligible, and must comply with a CRS financial application process; unless the applicant agrees to pay 100% of the cost of all CRS services. If an applicant requests any state assistance with the cost of CRS services, they must apply for Title XIX or XXI.

If an applicant does not comply with the screening, does not apply when determined potentially eligible, and does not agree to pay 100% of the cost of CRS services, the CRS application is considered withdrawn. The applicant/family will be informed that they may re-apply to CRS when they are prepared to cooperate with these requirements.

To complete the Title XIX/XXI screening, the CRS Contractor:

1. Will provide CRS applicants or members who are not already enrolled in a Title XIX/XXI program with the current version of the Income Limits for AHCCCS Eligibility form (Attachment A).
2. Will encourage CRS applicants or members who are close to the income limits to apply for AHCCCS services with AHCCCS or DES/FAA.
3. Will not ask for income verification for purposes of screening for Title XIX/XXI.
4. If the CRS Contractor decides to assist an applicant with submitting an AHCCCS application, they should follow the steps outlined below in section D.

B. Financial Application Form for Non-Title XIX/XXI Enrolled Applicants

1. Non-Title XIX/XXI CRS applicants who meet the eligibility criteria for CRS must submit a financial application containing the following:
   a. The applicant's name, date of birth, and marital status;
   b. If the applicant is a child, the name and employer/work address, if applicable, of at least one parent of the applicant;
   c. Whether the applicant is covered by health insurance;
   d. Identification of individuals in the household;
   e. The earned and unearned income received by any individual in the household;
   f. Any paid and unpaid medical expenses incurred by any individual in the household in the last twelve (12) months; and
   g. Any child care expenses and whom they are paid for.
2. The financial application must be signed and dated by the applicant or, if the applicant is a child, of at least one parent of the applicant.

C. Documentation to Determine Financial Classification

1. Non-Title XIX/XXI CRS applicants must provide the following documentation with the financial application:
   a. Documented evidence of all unearned income received by any individual in the household, such as cancelled checks or court orders for child support payments;

b. Documented evidence of all paid and unpaid medical expenses incurred by any individual in the household during the 12 months prior to the date of application; and
c. If an individual in the household is employed, copies of the individual's pay stubs for the thirty (30) calendar days prior to the date of the applicant's referral or written verification from the employer of the income;
d. If an individual in the household is self-employed, the individual's:
   i. Federal tax return, including a schedule C, most recently filed by the individual; and
   ii. Most recent quarterly financial statement signed and dated by the individual.
e. Documentation of any child care expenses.

2. In addition, if applicable, the applicant shall also bring documented evidence of:
   a. Any court award or settlement related to the applicant's CRS condition, and
   b. Any expenditures from the court award or settlement made for medical services.

D. Assisting Applicant's with Submitting Applications for Title XIX

Assisting CRS applicants with completion and submission of an application is not required; however, if the CRS Contractor chooses to provide assistance, the following procedures should be followed:

1. Prior to an application for Title XIX being submitted to the Department of Economic Security (DES)/Family Assistance Administration (FAA), the CRS designee shall ensure that the applicant has signed and dated the application.
2. The CRS designee shall gather the necessary verifications (e.g., income, citizenship, identity, age, address). Citizenship verification may be copied by the CRS designee, but the copies must be stamped "DES-Copy of Original", and include the date and name of the CRS designee making the copies.
3. The CRS designee will fax the completed application, any copies of verification, and the completed *Children's Rehabilitative Services (CRS) Referral Application Process Turn Around Document (TAD)* (Attachment 1) to the FAA local office which serves the applicant's zip code within 24 hours of receipt. With the use of the TAD, eligibility will be determined within ten (10) business days of receipt of the application in the local office versus the standard forty-five (45) business days.
4. The applicant will be contacted by FAA if additional information or verification is required.
5. Once the eligibility determination has been completed by FAA, a notice will be sent to the applicant.
6. FAA completes the DES portion of the TAD received from CRS and faxes it to the CRS designee at the fax number listed on the TAD.

Attachment 1

ARIZONA DEPARTMENT OF HEALTH SERVICES
CHILDREN'S REHABILITATIVE SERVICES
MEMBER PAYMENT RESPONSIBILITY WORKSHEET

CASE NAME_____ DATE_____

A. HOUSEHOLD INCOME GROUP		
1.	6.	11.
2.	7.	12.
3.	8.	13.
4.	9.	14.
5.	10.	15.

FAMILY SIZE

B. UNEARNED INCOME

Yes	No	DOES ANYONE RECEIVE OR HAS ANYONE APPLIED FOR ANY OF THE FOLLOWING:	WHO	TOTAL AMOUNT	HOW OFTEN PAID	ANNU AMOU
☐	☐	1. Social Security benefits? (SSA)		$0.00	monthly	
☐	☐	2. Supplemental Security Income (SSI)		$0.00	monthly	
☐	☐	3. Veteran's benefits, GI or other military benefits?		$0.00	monthly	
☐	☐	4. Railroad retirement or other retirement benefits?		$0.00	monthly	
☐	☐	5. Cash assistance (TANF, GA, EA, BIA-GA, SPP, TC)?		$0.00	monthly	
☐	☐	6. Unemployment Insurance (UI) benefits?		$0.00	monthly	
☐	☐	7. Industrial Compensation, Worker's Compensation, other disability?		$0.00	monthly	
☐	☐	8. Money from friends or relatives, including gifts and loans?		$0.00	monthly	
☐	☐	9. Child support, alimony, spousal maintenance?		$0.00	monthly	
☐	☐	10. Income from land lease?		$0.00	monthly	

		11. Income from rent or sale of land, buildings, etc.?		$0.00	monthly
		12. Prizes, awards, lottery winnings?		$0.00	monthly
		13. Payment from insurance settlements?		$0.00	monthly
		14. Other?		$0.00	monthly
15. TOTAL UNEARNED INCOME					

C. EARNED INCOME								
WAGE EARNER 1			WAGE EARNER 2			WAGE EARNER 3		
1.1 Name			1.2 Name			1.3 Name		
2.1 Gross Pay		$0.00	2.2 Gross Pay		$0.00	2.3 Gross Pay		
3.1 How Often Paid		weekly	3.2 How Often Paid		weekly	3.3 How Often Paid		
4.1 Annual Pay		$0.00	4.2 Annual Pay		$0.00	4.3 Annual Pay		
Verified	select		Verified	select		Verified	select	
If Collateral Contact Statement, who, when, and telephone number			If Collateral Contact Statement, who, when, and telephone number			If Collateral Contact Statement, who, when, a telephone number		

5. ANNUAL GROSS INCOME (Line C.4.1+ C.4.2+ C.4.3+ B.15)	
TITLE XXI (KIDSCARE) ELIGIBLE Below 200% FPL	**ERROR (Family Siz**

Page 2, CRS Member Payment Responsibility Worksheet

GROSS INCOME AS A PERCENT OF THE FEDERAL POVERTY LEVEL If member appears to be Title XIX eligible based solely on gross income, it is not necessary to complete section D, E, and F. Title XIX eligibility varies by age as follows: 140% for under age 1 133% for age 1 through 5 100% for age 6 and above If member's income is over these limits, continue on to sections D, E, and F to determine if allowable deductions will bring the adjusted income to within limits.	**0%**

D. DEDUCTIONS FROM INCOME FOR MEDICAL EXPENSES			
1. PAID MEDICAL/DENTAL EXPENSES		Total amount paid within the last 12 months	
Verified	select	If Collateral Contact Statement, who, when, and telephone number	
2. UNPAID MEDICAL/DENTAL EXPENSES		Total amount unpaid	
Verified	select	If Collateral Contact Statement, who, when, and telephone number	
3. HEALTH INSURANCE		Annual Amount	
		Premium Amount	$0.00

		How Often Paid				weekly
Verified	select	If Collateral Contact Statement, who, when, and telephone number				
E. DEPENDENT CARE DEDUCTIONS						
		CHILD 1	CHILD 2	CHILD 3	CHILD 4	CHILD 5
1. Name of child receiving care						
2. Name of person paying for care						
3. Amount of payment		$0.00	$0.00	$0.00	$0.00	$0.00
4. How often paid		weekly	weekly	weekly	weekly	weekly
5. Annual amount paid		$0.00	$0.00	$0.00	$0.00	$0.00
6. Age of child						
7. Annual maximum	full time	$0.00	$0.00	$0.00	$0.00	$0.00
8. Deduction allowed (Line E.5-E.7)		$0.00	$0.00	$0.00	$0.00	$0.00
9. Verified	select	If Collateral Contact Statement, who, when, and telephone number				
10. TOTAL DEPENDENT CARE (Total for all children)						
F. OTHER DEDUCTIONS						
1. COST OF EMPLOYMENT (COE X ANTICIPATED MONTHS OF EMPLOY)		Sum of all months of employment for people employed			0	
2. CHILD SUPPORT PAID				$0.00	monthly	
G. ADJUSTED INCOME						
1. ANNUAL GROSS INCOME (Line C.5)						
2.TOTAL DEDUCTIONS (Line D.1+D.2+D.3+E.10+F.1+F.2)						
3. ADJUSTED INCOME (Line G.1-G.2)						
ADJUSTED INCOME AS A PERCENT OF THE FEDERAL POVERTY LEVEL						
Title XIX eligibility varies by age as follows:						**0%**
140% for under age 1						
133% for age 1 through 5						
100% for age 6 and above						
CRS MEMBER PAYMENT RESPONSIBILITY						**ERROR (Family Siz**

revised 01/03/2008

Attachment 2

Children's Rehabilitative Services (CRS)
Referral Application Process
Turn Around Document (TAD)

Number of Pages including Cover: _____

Date sent to DES: _____ **CRS Patient Name:** _____

To DES Contact:	**From CRS Contact:**	**To CRS Contact:**
FAX Number ***(Include Area Code)*****:**	**FAX Number** ***(Include Area Code)*****:**	**FAX Number** ***(Include Area Code)*****:**
Phone No ***(Include Area Code)*****:**	**Phone No** ***(Include Area Code)*****:**	**Phone No** ***(Include Area Code)*****:**

Verification Documents	**List the document used for verification**
Residence	
Identity	
Citizenship	
Alien Status (when applicable)	
Social Security Number	
Dependent Care Expense	
Income	
Include Copy of Application	Date of Application:

To Be Completed by DES and Returned to Children's Rehabilitative Services		
Case Name:	Case Number:	
Date TAD/Documents Received at DES:	Effective Date of Eligibility:	Application Denied ï Reason:

Date Notice Sent to Applicant:	Eligibility Name:	Phone No:	Site Code:

Completion Instruction for
Children's Rehabilitative Services (CRS) Referral Process
Turn Around Document (TAD)

A. Purpose. This form will enable the CRS provider and Department of Economic Security (DES) staff to transmit information for the Medical Assistance eligibility process. It will also enable the provider to identify the information used to verify the factors of eligibility being sent to DES. This form will also provide a means for DES staff to send the Medical Assistance determination information to the provider.

B. Completion. All items are self-explanatory except the following:

1. The provider completes the top portion.

2. The DES local office completes the portions marked **To Be Completed By DES and Returned to Children's Rehabilitative Services**.

   Complete a systems check to determine whether the applicant has an ACTIVE, INACTIVE, or PENDING case.

   If the case is **DENIED**, enter the specific reason for denial. The reason code is **not** acceptable.

C. Routing. FAX to the DES local office.

D. Retention. Retain in accordance with the providerôs and DESôpolicies and procedures.

Section 4.4 Financial Determination for Non-Title XIX/XXI Enrolled Applicants

A. Household Income Group

At the time of application or redetermination, the CRS Contractor shall identify a member's household income group as:

1. If the member is living with a parent of the member, that parent's household group;
2. If the member is living with an individual other than a parent of the member and a parent of the member claims the member as a dependent for tax purposes for the current tax year, that parent's household income group; or
3. If the member is living with an individual other than a parent of the member and neither parent claims the member as a dependent for tax purposes, the household income group of the individual with whom the member lives.

In order to calculate the CRS applicant's or member's payment responsibility, use the income of the applicant's or member's household (A.A.C. R9-7-305). The following individuals, when residing together, constitute a CRS household income group:

1. A married couple and children of either or both parents;
2. An unmarried couple and the children of either or both parents;
3. A married couple when both are over the age of 21 years;
4. A married couple when either one or both are under age 21 years with no children;
5. A single parent and his/her children;
6. An applicant or a member between the ages of 18 years and 21 years;
7. A child who does not live with his/her parent; and
8. An individual who is absent from a household shall be included in the household income group if absent:
   a. For 30 days or less;
   b. For the purpose of seeking employment or to maintain a job;
   c. For service in the military or for an educational purpose and the applicant's parent claims the child as a dependent on the parent's income tax return;
9. When a parent of an applicant claims the applicant as a dependent on the parent's income tax return, the parent shall also be included in the household income group.

B. Unearned Income

Unearned income is defined as monies received for which no labor was expended. When payment from any unearned income source is reduced due to a prior overpayment, only the portion actually received will be considered. The following list includes types of unearned income, which, unless otherwise specified, shall be counted in the month of receipt. The list also includes exclusions or other treatment of unearned income amounts that vary depending on whether the program applied for is Title XIX or Title XXI.

1. Agent Orange settlement fund payments are excluded.

2. Alaska Native Regional and Village Corporation Payments. Exclude the first $2,000 per calendar year for Title XIX and Title XXI persons.
3. Aleutian and Pribilof Islanders Relocation Payments are excluded.
4. Alimony or Spousal Maintenance payments are counted as unearned income. Alimony or spousal maintenance payments are court-ordered support payments, which a legally divorced or separated person pays to the spouse.
5. Assistance Payments are counted as unearned income. Assistance Payments are payments received from Arizona or Temporary Assistance for Needy Families (TANF) payments from another state. Arizona assistance payments programs include, but are not limited to, TANF, General Assistance, Tuberculosis Control, and Emergency Assistance.
6. Bureau of Indian Affairs (BIA)
    a. BIA General Assistance Payments are considered to be public assistance payments and as unearned income.
        ii. Tribal Work Experience Program or Tribal Assistance Project Program. The portion of the income, which is an incentive payment, is disregarded.
        iii. BIA or Tribal Work Study Program provides for educational and living expenses. Only payments for living expenses, which are paid directly to the student, are counted as unearned income.
7. Child Support is any payment received from an absent parent. Child support does not have to be court ordered. An amount in excess of $50.00 per child of child support received in a given month shall be counted as unearned child support income.
8. Cash contributions from agencies or organizations other than the ADHS or AHCCCS are excluded if the contributions are not intended for the following items:
    a. food;
    b. rent or mortgage payments for shelter;
    c. utilities;
    a. household supplies such as bedding, towels, laundry, cleaning, and paper supplies;
    b. public transportation fares for personal use;
    c. basic clothing or diapers; or
    d. personal care and hygiene items, such as soap, toothpaste, shaving cream, and deodorant.
9. Contributions and Complementary Assistance
    a. Cash contributions from relatives and other persons shall be counted as unearned income if not considered as gifts or child support.

        A household member who is receiving SSI may voluntarily contribute to the household. In order for this contribution to be considered unearned income:
        i. The contributor shall not be a person whose income would be required to be included in the individual/family's adjusted gross income if he/she were not receiving Supplemental Security Income (SSI);
        ii. The contributor's income is not otherwise considered available to be included in the individual/family's adjusted gross income; or

iii. The contribution shall be for other than the contributor's share of household expenses.

10. Disaster Assistance.
    a. For Title XIX (Medicaid) payments are excluded;
    b. For Title XXI (Kids Care) payments are counted as unearned income.
11. Earnings from high school on-the-job training programs are excluded.
12. Educational Benefits. The amount of the loan, grant or scholarship remaining after subtracting applicable deductions is averaged over the period of months which the loan, scholarship, or grant is intended to cover. The resulting monthly income shall be counted as unearned income.
13. Educational grants or scholarships funded by the United States Department of Education or from a Veterans Education assistance program or the Bureau of Indian Affairs student assistance program are excluded.
14. Energy Assistance Payments from federal government programs that provide assistance to prevent fuel-cut offs and promote energy assistance are excluded.
15. Fair Labor Standard Act supplemental payments are excluded.
16. Food Stamps and other food programs are excluded.
17. Foster Care Payments.
    a. Payments are excluded for Title XIX (Medicaid);
    b. Payments are counted as unearned income for Title XXI (Kids Care).
18. Emergency Assistance Payments received directly by an applicant or recipient of TANF are excluded.
19. Gifts. Small, nonrecurring cash gifts, including but not limited to gifts for holidays, birthdays, or graduation that exceed $500 per calendar year shall be counted as unearned income.
20. Housing assistance from the U.S. Department of Housing and Urban Development (HUD) is excluded.
21. Indian Gaming Profit Distribution is counted as unearned income.
22. Indian Payments to Specific Native American Tribes or Groups under Public Law are excluded.
23. Individual Development Account. Funds set aside in an individual Development Account under A.A.C. R6-12-404 are excluded.
24. Industrial Compensation payments made by agencies in the Arizona Industrial Commission, similar in other states concerning workers injured on the job, are counted as unearned income.
25. Insurance payments or benefits shall be counted as unearned income in accordance with the following:
    a. Insurance payments made directly to the insured shall be counted;
    b. Insurance payments designated as payment for a specific bill, debt, or estimate shall be counted; and
    c. Insurance benefits that are used for, or are intended to meet, basic daily needs shall be counted.
26. Interest, Dividend, and Royalty payments are made directly to the individual (i.e., interest from checking or savings accounts). Funds left on deposit or converted into additional securities shall be considered a resource and not counted as income.
27. Japanese American Restitution Payments are excluded.

28. Lease or Royalty from Indian Land. On some reservations, individuals own or are allotted part of the reservation land that they may lease to others depending on the agreement with the tribe or stipulations on the land. In addition, in some areas, an individual family may own land that is not part of the reservation, in which case the family may lease the land. All of these land lease situations shall be treated as follows:
    a. All land lease income shall be counted; and
    b. The frequency of the land lease income varies, as follows:
        i. Land lease income shall be counted when it is received by the BIA and posted to the individualôs account, making the funds available for pick-up by the individual;
        ii. If land lease income is available every month, the income shall be counted monthly;
        iii. Land lease income that is received less frequently than monthly shall be considered income at the time it is available; and
        iv. Funds in the BIA account prior to the month of application shall be counted as a resource and not as income. All deposits of land lease monies made after the application date are counted as income.
29. Legal Settlements/ Insurance Award, less attorneyôs fees, shall be counted as unearned income (i.e., lump sum compensation).
30. Loans. Money received from a private individual, commercial institution, or educational institution when repayment is expected and promised. A loan may be documented or may be based on a verbal agreement. A loan is differentiated from a gift or contribution because the person who made the loan expects repayment within an amount of time agreed upon.
    a. Title XIX (Medicaid) excludes loans from unearned income (See Interest and Dividends for loan repayment);
    b. Title XXI (Kids Care) counts all loans as unearned income except for certain educational loans.
31. Mortgages and Sales Contracts. Payments received from mortgages or sales contracts shall be considered unearned income for the amount of payment, which is interest.
32. Non-recurring cash gifts that do not exceed $30 per person in any calendar quarter are excluded.
33. Prizes, awards, and lottery winnings may be earned income (food, clothing, shelter, and non-cash items are excluded from unearned income).
34. Radiation Exposure Compensation Payments are excluded.
35. Railroad Retirement benefits shall be counted as unearned income.
36. Reimbursement for work-related expenses that do not exceed the actual expense amount are excluded.
37. Relocation Payments are excluded.
38. Rental Income. Income generated solely from rental payment, and not for services provided, shall be counted as unearned income.
39. Reparation Payments to Holocaust Survivors are excluded.
40. Retirement Income, Pensions and Annuities shall be counted as unearned income.
41. Ricky Ray Hemophilia Relief Fund Act of 1998 payments are excluded.

42. Social Security Administration (SSA) Benefits.
    a. SSA Benefits (sometimes referred to as RSDI--Retirement Survivors, and Disability Insurance) are granted to eligible wage earners and/or to their dependents or survivors.
    b. SSA Educational Benefits for persons 18 to 22 years of age who are full-time students.
    c. When RSDI Benefits are paid to a representative payee on behalf of a member of the applicant/family and the payee lives in the same household as the applicant/family, the RSDI Benefits shall be counted as income. When the representative payee does not live in the household, the RSDI Benefits shall be counted only to the extent that the payee makes them available for the support of the beneficiary.
43. Spina Bifida Payments are excluded.
44. Stocks sold shall be counted as unearned income.
45. Strike pay shall be counted as unearned income.
46. Supplemental Security Income (SSI). Payments to aged and disabled individuals whose other income is below the Federal Benefit Rate and who also meet other requirements. The SSI amount added to the amount of the other income less certain deductions equals the Federal Benefit Rate (FBR).
    a. SSI may be paid to a representative payee on behalf of the entitled person. When SSI is paid to a representative payee follow the procedure used for Social Security benefits paid to a representative payee.
    b. A child who receives SSI has Medicaid coverage and is therefore ineligible for Kids Care. When a person receiving SSI is living in a Kids Care Income Group the SSI income is counted as unearned income for Title XXI (Kids Care) and excluded for Title XIX (Medicaid).
47. TANF income shall be counted as unearned income.
48. Tax Refunds. Federal and State income tax refunds including any portion identified as Earned Income Tax Credit (EITC) shall be disregarded as income.
49. Trust Funds. All payments received by the individual/family from a trust fund shall be counted as unearned income.
50. Unemployment Insurance (UI) Benefits, which is unearned income, shall be considered to be received by an individual on the third postal workday following the date benefits are mailed.
    a. A postal workday is any day other than a Sunday or Federal holiday.
    b. The first day is the first postal work day following the mailing date.
51. Vendor payment made by an organization or person who is not a member of the family or MED unit, to a third party to cover family expenses is excluded.
52. VeteransôAdministration Benefits (VA). Payments to veterans, their dependents, or survivors. Includes Retirement, Survivors, and Disability Benefits and pension adjustments for medical expenses. VA adjustment for medical expenses may be included on the check with the pension.
    a. Title XXI (Kids Care) counts all VA benefits as unearned income.
    b. Title XIX (Medicaid) excludes from unearned income the portion of the pension payments, which are an adjustment for medical expenses. This adjustment includes VA Aid and Attendance. The remainder of the pension check is treated as unearned income.

53. VolunteersôCash Compensation. Payments to volunteers in some government programs to help cover expenses they incur by volunteering. The amount must be less than the Federal Minimum wage. These programs include:
    a. VISTA;
    b. ACTION; and
    c. Older Americans Act programs.

    If the volunteer cash compensation is less than the federal minimum wage, the entire amount of compensation is excluded from unearned income. If the amount of compensation is greater than or equal to the federal minimum wage, the amount is treated as wages (see C. 17.)
54. VISTA income shall be excluded if it does not exceed the State or Federal minimum wage, whichever is greater.
55. Winnings from bingo or any other form of gambling shall be counted as unearned income.
56. WIC Payments are excluded.

C. Earned Income

Earned income is defined as either cash or in-kind income received from the receipt of wages, salaries, commissions, or profit from activities in which an individual is engaged as a self-employed person or an employee. The following list includes sources of earned income, which shall be counted in the month of receipt. The list also includes exclusions or other treatment of earned income amounts that vary, depending on whether the program applied for is Title XIX or Title XXI. The following list is not all-inclusive.

1. Arizona Training Program. Salaries to handicapped persons working in a sheltered workshop situation are considered earned income.
2. Arizona Works! Program. Earnings from the Arizona Works! Sponsored on-the-job training; or Public Service Employment or from full or part-time job entries resulting out of participation in Arizona Works, except work incentive payments and reimbursements for training related expenses, are counted as earned income.
3. Babysitting or Child Care Income. Earnings from babysitting, including DES Day Care, is counted as earned self-employment income. Any income from the Child Care Food Program is disregarded.
4. Blood and Plasma Sales. Earnings from these sales are considered earned self-employment income.
5. Can or Bottle Collections and Sales. Earnings from these sales are considered earned income.
6. Contract Income. Earnings received by individuals employed on a contractual basis (including school employees who are paid on a regular schedule for nine months on a twelve-month contract) are counted as earned income.
7. Housekeeper or Home Health Aides. Income earned as a housekeeper or home health care aide is counted as earned income.
8. In-Kind Income. The value of any item, which the individual receives in return for labor expended, is counted as earned income.
9. Job Opportunity and Basic Skills Training (JOBS). JOBS is a group of programs, including On-the-Job Training (OJT), Work Supplementation, Community Work Experience Program (CWEP), and other programs designed to help participants

rejoin the workforce. Participants may receive wages for full or part-time job participation or reimbursement for training-related expenses for participation, which is counted as earned income.

10. Job Training Partnership Act (JTPA):
    a. Income is counted as earned income for Title XXI (Kids Care).
    b. For Title XIX, the treatment of income is dependent on the student's status; Title XIX excludes income earned through JTPA by a student. A Job Corps participant in JTPA is always considered a student. If the JTPA participant is not a student, exclude income earned through JTPA for the first six months that the earnings are received during the calendar year. The six months do not have to be consecutive to qualify for this exclusion.
11. Jury Pay is counted as earned income.
12. Rental Income. Earned rental income includes any monies, less expenses, received from rental property when work is involved.
    a. Work may include, but is not limited to, managing rental property requiring maintenance, collection of rent, or accounting functions.
    b. If the individual does not work to maintain the property or records, rent is considered unearned income.
13. Self-Employment. Earned self-employment income includes income derived from a business enterprise such as, but not limited to, taking in roomers or boarders, ranching, farming, swap meet sales, cosmetic sales, babysitting, blood and plasma sales, janitorial services, guiding for hunting, or fishing or any wholesale or retail sales. An explanation of how to determine the applicable gross income to be used in the CRS member payment responsibility calculation follows:
    a. Gross business receipts are the total cash received from the business activity. This is the income before business expenses are deducted.
    b. Business expenses, sometimes called "overhead" expenses, include all expenses related to the production of goods and/or services. Allowable expenses include, but are not limited to:
        i. Costs of stocks or inventories;
        ii. Costs of operating machinery or equipment;
        iii. Rent, mortgage payments or property taxes on the business property (Note: only the interest on mortgage payments is an allowable expense; the principal is not an allowable expense);
        iv. Salaries paid to employees, as well as employer-paid benefits;
        v. Insurance; and
        vi. Advertising
    c. The following are not deductible as business expenses:
        i. Depreciation, unless declared for Federal income tax purposes;
        ii. Federal, state, or local income tax payments;
        iii. Entertainment expenses;
        iv. Personal transportation (including but not limited to transportation to and from work);
        v. Cost of purchasing capital equipment; and
        vi. Payments on the principal of loans.
        vii. Gross business receipts less business expenses equal the profit. The profit is the amount to be used in counting income.

14. Summer Youth Employment and Training Program (SYETP) Payments.
    a. Title XXI (Kids Care) counts the income as earned income; and
    b. Title XIX (Medicaid) excludes the income.
15. Work Study Program Income of College Students-Educational benefits paid to a college student.
    a. For both Title XIX and Title XXI, the payments are excluded as earned income when funded by the U.S. Department of Education;
    b. When the funding is from any other source, the payments are counted as wages; and
    c. See Educational Benefits also.
16. Vocational Rehabilitation sponsored on-the-job training is excluded as earned income.
17. Wages. Gross earnings from employment, prior to any deductions, garnishments, allowances or adjustments, are counted as earned income. Special benefits or deductions connected with employment earnings include:
    a. Advances, bonuses and commissions;
    b. Reimbursements - The amount of a reimbursement from an employer for a job-related expense which is in excess of the actual expense is counted as earned income;
    c. Sick pay and vacation pay; and
    d. Tips. The actual amount of tips received is counted as earned income

D. Deductions from Income

1. There are certain deductions from income that are allowed for the Title XIX (Medicaid or ALTCS) and Title XXI (Kids Care) programs. These allowances include deductions for dependent care and cost of employment. CRS allows the same deductions when calculating income to determine a member's payment responsibility.
    a. Dependent Care:
       If the household income group received earned income and anticipates receiving earned income for the next 12 months, a deduction may be taken for the care of a child or incapacitated adult if written proof of the disability or incapacitation is provided. Both the individual receiving the earned income and the individual receiving care must live in the family household.
       i. Child Care:
          1) This is the cost paid to any babysitter or day care provider with the following requirements:
          2) If the wage earner is employed on a full-time basis (86 hours or more per month), up to $200.00 per month per child less than two years of age will be deducted and up to $175.00 per month per child age two or older will be deducted.
          3) If the wage earner is employed on a part-time basis (less than 86 hours per month), up to $100.00 per month per child less than two years of age will be deducted and up to $88.00 per month per child age two or older will be deducted.

ii. Incapacitated Adult Care:
This includes costs paid to a provider for the care of an incapacitated adult. "Incapacity" is to be determined by a licensed physician or psychologist. A signed and dated statement is required.
1) If the wage earner is employed on a full-time basis (86 hours or more per month), up to $175.00 per month will be deducted.
2) If the wage earner is employed on a part-time basis (less than 86 hours per month), up to $88.00 per month will be deducted.

b. Cost of Employment:
For any employed individual or parent whose earned income is to be included in the household adjusted gross income, $90.00 may be deducted from earnings each month for the cost of employment to compensate for job-related personal expenses such as transportation, uniforms, and mandatory payroll deductions.

2. If the CRS eligible applicant or member is ineligible for Title XIX and Title XXI, the CRS Contractor shall take additional deductions from the income when determining CRS member payment responsibility. These are additional deductions allowed by CRS that are not allowed for Title XIX or Title XXI. These deductions should be taken from income only when the applicant or member is not being referred to Title XIX or Title XXI programs.
a. Health insurance premiums paid by the household income group within the previous twelve (12) months.
b. Unpaid medical and dental expenses incurred within the twelve (12) months prior to the date of application or at the time of a redetermination by any individual in the household income group which are the household's financial responsibility and not subject to any applicable third party payment.
a. Paid Medical and dental expenses incurred within the twelve (12) months prior to the date of application or at the time of a redetermination by any individual in the household income group which are not subject to any applicable third party payment.
b. The first $50 of child support received by an individual in the household income group.

3. When an applicant's gross annual income is below 200% of the Federal Poverty Level (FPL) amounts for income and family size, the CRS Regional Contractor shall not request additional information from the applicant to verify deductions from income.

E. Calculation of Household Adjusted Gross Annual Income

CRS uses the adjusted gross annual income of the household income group to determine the payment responsibility for CRS services. The calculation of the adjusted gross annual income is completed in the following manner:

1. Determine the total income of the household income group. The total income includes both earned income and unearned income. The CRS Contractor may

use the income calculation worksheet provided by ADHS/CRSA, "Member Payment Responsibility Worksheet", to assist in documenting this calculation.

2. For a household whose individuals receive wages or salaries, calculate the annual wage by multiplying the frequency of pay periods in one year by the amount received in each pay period. For example, if the individual receives $500 every two weeks, the annual wage is $500 x 26 pay periods in one year for a total wage of $13,000.
3. For a household whose individuals are self-employed or seasonal workers, use the previous year's annual earned income as the total earned income. If the self-employed individual was not self-employed for a full year, calculate annual earned income based upon those months of income since self-employment began.
4. Determine cost of dependent care and the cost of employment deductions for the past 12 months. Refer to D. above, Deductions from Income.
5. The adjusted gross annual income of the household income group equals the earned income plus the unearned income minus the annual allowable deductions from income.
6. The "Member Payment Responsibility Worksheet" (Attachment 1) identifies the adjusted income as a percentage of the Federal Poverty Level (FPL) and whether that applicant is responsible for 0% or 100% of the cost of CRS services.
7. The CRS Contractor must complete the Member Payment Agreement form (Attachment 2) indicating that member payment responsibility as 0% or 100% pay and provide it to the member for signature. A signed Member Payment Agreement form must be received prior to providing any services.

Attachment 1

ARIZONA DEPARTMENT OF HEALTH SERVICES
CHILDREN'S REHABILITATIVE SERVICES
MEMBER PAYMENT RESPONSIBILITY WORKSHEET

CASE NAME _____ DATE _____

A. HOUSEHOLD INCOME GROUP		
1.	6.	11.
2.	7.	12.
3.	8.	13.
4.	9.	14.
5.	10.	15.

FAMILY SIZE

B. UNEARNED INCOME

Yes	No	DOES ANYONE RECEIVE OR HAS ANYONE APPLIED FOR ANY OF THE FOLLOWING:	WHO	TOTAL AMOUNT	HOW OFTEN PAID	A
☐	☐	1. Social Security benefits? (SSA)		$0.00	monthly	
☐	☐	2. Supplemental Security Income (SSI)		$0.00	monthly	
☐	☐	3. Veteran's benefits, GI or other military benefits?		$0.00	monthly	
☐	☐	4. Railroad retirement or other retirement benefits?		$0.00	monthly	
☐	☐	5. Cash assistance (TANF, GA, EA, BIA-GA, SPP, TC)?		$0.00	monthly	
☐	☐	6. Unemployment Insurance (UI) benefits?		$0.00	monthly	
☐	☐	7. Industrial Compensation, Worker's Compensation, other disability?		$0.00	monthly	
☐	☐	8. Money from friends or relatives, including gifts and loans?		$0.00	monthly	
☐	☐	9. Child support, alimony, spousal maintenance?		$0.00	monthly	
☐	☐	10. Income from land lease?		$0.00	monthly	

		11. Income from rent or sale of land, buildings, etc.?		$0.00	monthly
		12. Prizes, awards, lottery winnings?		$0.00	monthly
		13. Payment from insurance settlements?		$0.00	monthly
		14. Other?		$0.00	monthly
15. TOTAL UNEARNED INCOME					

C. EARNED INCOME

WAGE EARNER 1				WAGE EARNER 2			WAGE EARNER 3		
1.1 Name				1.2 Name			1.3 Name		
2.1 Gross Pay			$0.00	2.2 Gross Pay		$0.00	2.3 Gross Pay		
3.1 How Often Paid			weekly	3.2 How Often Paid		weekly	3.3 How Often Paid		
4.1 Annual Pay			$0.00	4.2 Annual Pay		$0.00	4.3 Annual Pay		
Verified		select		Verified	select		Verified	select	
If Collateral Contact Statement, who, when, and telephone number				If Collateral Contact Statement, who, when, and telephone number			If Collateral Contact Statement, who, w telephone number		

5. ANNUAL GROSS INCOME (Line C.4.1+ C.4.2+ C.4.3+ B.15)	
TITLE XXI (KIDSCARE) ELIGIBLE Below 200% FPL	**ERROR (Fan**

Page 2, CRS Member Payment Responsibility Worksheet

GROSS INCOME AS A PERCENT OF THE FEDERAL POVERTY LEVEL	
If member appears to be Title XIX eligible based solely on gross income, it is not necessary to complete section D, E, and F. Title XIX eligibility varies by age as follows: 140% for under age 1 133% for age 1 through 5 100% for age 6 and above	**0%**
If member's income is over these limits, continue on to sections D, E, and F to determine if allowable deductions will bring the adjusted income to within limits.	

D. DEDUCTIONS FROM INCOME FOR MEDICAL EXPENSES

1. PAID MEDICAL/DENTAL EXPENSES		Total amount paid within the last 12 months
Verified	select	If Collateral Contact Statement, who, when, and telephone number
2. UNPAID MEDICAL/DENTAL EXPENSES		Total amount unpaid
Verified	select	If Collateral Contact Statement, who, when, and telephone number
3. HEALTH INSURANCE		Annual Amount

		Premium Amount	$0.00
		How Often Paid	weekly
Verified	select	If Collateral Contact Statement, who, when, and telephone number	

E. DEPENDENT CARE DEDUCTIONS						
		CHILD 1	CHILD 2	CHILD 3	CHILD 4	CHILD 5
1. Name of child receiving care						
2. Name of person paying for care						
3. Amount of payment		$0.00	$0.00	$0.00	$0.00	$0.00
4. How often paid		weekly	weekly	weekly	weekly	weekly
5. Annual amount paid		$0.00	$0.00	$0.00	$0.00	$0.00
6. Age of child						
7. Annual maximum	full time	$0.00	$0.00	$0.00	$0.00	$0.00
8. Deduction allowed (Line E.5-E.7)		$0.00	$0.00	$0.00	$0.00	$0.00
9. Verified	select	If Collateral Contact Statement, who, when, and telephone number				
10. TOTAL DEPENDENT CARE (Total for all children)						

F. OTHER DEDUCTIONS			
1. COST OF EMPLOYMENT (COE X ANTICIPATED MONTHS OF EMPLOY)	Sum of all months of employment for people employed	0	
2. CHILD SUPPORT PAID	$0.00	monthly	

G. ADJUSTED INCOME	
1. ANNUAL GROSS INCOME (Line C.5)	
2.TOTAL DEDUCTIONS (Line D.1+D.2+D.3+E.10+F.1+F.2)	
3. ADJUSTED INCOME (Line G.1-G.2)	
ADJUSTED INCOME AS A PERCENT OF THE FEDERAL POVERTY LEVEL Title XIX eligibility varies by age as follows: 140% for under age 1 133% for age 1 through 5 100% for age 6 and above	**0%**
CRS MEMBER PAYMENT RESPONSIBILITY	**ERROR (Fan**

Attachment 2 – English

Arizona Department of Health Services/ Office for Children with Special Health Care Needs
Children's Rehabilitative Services

MEMBER PAYMENT AGREEMENT FOR NON-AHCCCS/KIDSCARE MEMBERS

Patient Name_____D.O.B._____

Children's Rehabilitative Services shall provide authorized services. My payment responsibility category will be:

☐ 0% based on AHCCCS rates
☐ 100% based on AHCCCS rates

Does patient have Medical Insurance? Yes ☐ No ☐

I agree that any moneys received by me as a court award or settlement of a claim which provides for medical care of the member shall be used to pay CRS providers for care which is authorized and provided. I agree that when insurance benefits, court awards, claim settlements or other third party benefits are available, I shall make them available before CRS funds shall be used to provide care for the member or shall be used to reimburse CRS or the CRS contractor for all care provided to the member. If I receive and convert any benefits described by this subsection to my personal use and not for payment of the member's CRS services, I shall be personally responsible for the payment of the services for which the benefits were intended to pay.

If applicable, payments will become due and payable after receipt of statement of charges. I agree to provide all information necessary to enable CRS and CRS providers to collect such insurance. I agree to notify CRS within ten (10) days of any financial or insurance changes that would affect my financial eligibility.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize CRS to release information necessary for the completion of hospital, other providers, and medical insurance claims. I also authorize CRS to exchange information with DES or AHCCCS and other insurance companies as necessary to determine financial eligibility.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize any insurance company with whom I have coverage, to make payment directly to the hospital, clinic, physician or other CRS provider rendering service. I also agree to forward any insurance moneys, received for services rendered through Children's Rehabilitative Services, to the provider of such service. I agree to send copies of all explanation of benefits received by me from my health insurance company to CRS or CRS providers.

I agree that I have been deemed eligible for CRS services at 100% based on AHCCCS rates with insurance and will be responsible for any co-pays required of me by my insurance company. Initials:_____

I certify that I have read this agreement, received a copy, and am authorized to act for the member and as his or her parent to execute and accept the terms, conditions and authorizations set out above.

Expiration Date _____

Financially Responsible Person_____ Date _____

CRS Financial Staff _____ Date of Agreement_____

STATE ONLY

Family Gross Income	**Family Total Deductions**	**Family Size**

Revised: 11/02/06

Attachment 2 – Spanish

Departamento de Servicios de Salud de Arizona/ Oficina para Niños con Necesidades Especial de Salud
Servicios de Rehabilitación de Niños
Compromiso de Pago del Miembro para Personas que no son Miembros de AHCCCS/KidsCare

Nombre del Paciente:_____ **Fecha de Nacimiento:** _____

Los Servicios de Rehabilitación Para Niños van a proveer los servicios autorizados. Mi responsabilidad para mis pagos en la siguiente categoria sera:

□ 0% basado en la tarifa de AHCCCS
□ 100% basado en la tarifa de AHCCCS

¿ Tiene el paciente aseguranza/ seguro médico? □ Si □ No

Yo estoy de acuerdo que cualquier dinero que yo reciba de una reclamación u otorgado o asignado por corte, éste destinado para pagar los costos médicos y servicios autorizados que provee CRS. Yo estoy de acuerdo que cuándo esten disponible los beneficios de seguro médico, o fondos asignados por corte u otorgados o si hay un tercer partido de beneficios médicos disponible, yo aseguro que esten disponible para pagar por los servicos o reembolse a CRS, o el contratista de CRS que provee los servicios al paciente antes de usar los fondos de CRS . Si yo recibó y conviertó cualquier parte de estos fondos o beneficios describidos en esta subsección, para mi propio interés, en vez de pagar por servicios proveidos por CRS para el paciente, yo sere personalmente responsable de pagar la cuenta por los servicios.

Si applicable, al recibir la declaración del cobro se cumple el abono. Yo estoy de acuerdo de proveer toda la información que sea necesaria para que CRS y los proveedores de CRS puedan colectar de la aseguranza médica. Yo estoy de acuerdo de informar a CRS dentro de (10) días de cualquier cambio sean beneficios médicos o financieros que pueden tener efecto en mi elegibilidad.

Autorización de Permiso

Por éste medio doy mi autorización a CRS de intercambiar la información necesaria para completar la reclamación del hospital, otros proveedores o seguro médico. Tambien doy mi autorización a CRS de intercambiar información con DES o AHCCCS y a otras compañias de seguro médico a como sea necesario para determinar elegibilidad financiera.

Asignación de Beneficios Médicos

Yo doy mi permiso a cualquier compañia de aseguranza con quién yo tengo cobertura, de hacer los pagos directamente al hospital o médico, clinica, o a otro proveedor de CRS que rindió servicio. Tambien estoy de acuerdo de remitir los dineros que yo reciba del seguro médico a los Servicios de Rehabilitación de Niños (CRS), por los servicios rendidos. Estoy de acuerdo de enviar copias de las explicaciones de los beneficios que yo reciba de la compañia de seguro médico a CRS o a los proveedores de CRS.

Yo estoy de acuerdo que soy considerado/a elegibile para los servicios de CRS al 100% con seguro medico, basado en la tarifa de AHCCCS con seguro médico, y sere responsable por los deducibles y co-pagos que se requieren de mi por la compañia de seguro médico. Iniciales:_____

Yo atestigüo que e leìdo ésta declaración, que recibi una copia, y que tengo la autorización para actuar por el paciente, y como su padre/guardian, tengo el derecho de ejecutar y aceptar los terminos, condiciones y autorizaciónes indicada anteriormente.

Fecha de Vencimiento _____

Persona Responsable Financieramente:_____
Fecha:_____

Personal Financiero de CRS: _____
Fecha:_____

SOLAMENTE PARA EL PROPÓSITO DEL ESTADO

Ingresos Annual de la Familia	Deducibles Total de la Familia	Tamaño de Familia

Revised: 11/02/06

Section 4.5 Member Payment Responsibility Standards

A. Financial Responsibilities of Members

1. When the CRS Contractor identifies a CRS member as having private health insurance, they shall ensure collection of payment for CRS Services as defined below and in Section 7.3 of this policy manual.
2. The following CRS members shall not pay for CRS services:
   a. Wards of the state or court;
   b. DES adoption subsidy children;
   c. DES/CMDP foster children;
   d. AHCCCS (Title XIX and XXI) enrolled members; and
   e. State Only members with an adjusted gross income of less than 200% of the current Federal Poverty Level amount for income and family size.
3. State Only Members with Private Health Insurance
   State Only members with private health insurance who have an adjusted gross income of greater than or equal to 200% of the current Federal Poverty Level (FPL) amount for income and family size shall pay the following for CRS services:
   a. Co-payments according to the requirements of the private health insurance, excluding CRS Clinic visits and Outreach Clinic visits;
   b. Deductibles according to the requirements of the private health insurance; and/or
   c. Coinsurance according to the requirements of the private health insurance; and.
   d. 100% of the following rates if the private health insurance denies payment due to out-of-network or non-covered service:
      i. The AHCCCS hospital per diem rates for all inpatient hospital services;
      ii. The AHCCCS hospital outpatient cost to charge ratio for all hospital outpatient services; and
      iii. The AHCCCS fee schedule for all physician and supplier services.
4. State Only Members without Private Health Insurance
   State Only members without private health insurance who have an adjusted gross income of greater than or equal to 200% of the current Federal Poverty Level (FPL) amount for income and family size shall pay 100% of the following rates for CRS services:
   a. The AHCCCS hospital per diem rates for all inpatient hospital services;
   b. The AHCCCS hospital outpatient cost to charge ratio for all hospital outpatient services; and
   c. The AHCCCS fee schedule for all physician and supplier services.
5. The CRS Contractor shall ensure that a member is not denied services because of the member's inability to pay a co-payment or deductible.

B. Member Payment Agreement and/or Assignment of Benefits

1. Before an applicant can receive an initial evaluation, diagnostic testing or receive a CRS service from the CRS Contractor, the member payment responsibility

must be determined according to Section 4.4, Financial Determination for Non-Title XIX/XXI Enrolled Applicants.

2.. Every non-AHCCCS applicant, or if the applicant is a minor, the parent of the non-AHCCCS applicant shall complete and sign a Member Payment Agreement for Non-AHCCCS/KidsCare Members form (Attachment 1) that acknowledges and accepts his/her financial responsibility;

3. Every applicant (AHCCCS and Non-AHCCCS) shall sign an agreement (Attachment 2) to assign benefits to CRS as follows:
   a. Assignment of insurance benefits to ADHS/CRSA and CRS providers;
   b. Agreement that any monies received by the member as a court award or settlement of a claim which provides for the medical care of the member shall be used to pay CRS providers for care which is authorized and provided;
   c. Agreement that when any insurance benefits, court awards, claim settlements or other third party benefits are available, they shall be exhausted before ADHS/CRSA funds shall be used to provide care for the member, or shall be used to reimburse ADHS/CRSA or the CRS Contractor for all care provided to the member; and
   d. Agreement that if the member receives and converts any benefits described by this subsection to the member's personal use and not for payment of the member's CRS services, the member shall be personally responsible for the payment of the services for which the benefits were intended to pay.

4. Signing Authority
   a. A parent must sign the Member Payment Agreement form (Attachment 2) for a minor child under 18 years old. When the applicant is a married or unmarried individual over 18 years old, the parent or guardian may sign the Member Payment Agreement form if the parent or guardian is exercising financial responsibility for the care and control of the applicant.
   b. The CRS applicant or applicant's spouse over 18 years old may sign the Member Payment Agreement form if the applicant or spouse is exercising the financial responsibility for the care and control of the applicant.

Attachment 1

Arizona Department of Health Services/ Office for Children with Special Health Care Needs
Children's Rehabilitative Services

MEMBER PAYMENT AGREEMENT FOR NON-AHCCCS/KIDSCARE MEMBERS

Patient Name_____ **D.O.B.**_____

Children's Rehabilitative Services shall provide authorized services. My payment responsibility category will be:

- ☐ 0% based on AHCCCS rates
- ☐ 100% based on AHCCCS rates

Does patient have Medical Insurance? Yes ☐ No ☐

I agree that any moneys received by me as a court award or settlement of a claim which provides for medical care of the member shall be used to pay CRS providers for care which is authorized and provided. I agree that when insurance benefits, court awards, claim settlements or other third party benefits are available, I shall make them available before CRS funds shall be used to provide care for the member or shall be used to reimburse CRS or the CRS contractor for all care provided to the member. If I receive and convert any benefits described by this subsection to my personal use and not for payment of the member's CRS services, I shall be personally responsible for the payment of the services for which the benefits were intended to pay.

If applicable, payments will become due and payable after receipt of statement of charges. I agree to provide all information necessary to enable CRS and CRS providers to collect such insurance. I agree to notify CRS within ten (10) days of any financial or insurance changes that would affect my financial eligibility.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize CRS to release information necessary for the completion of hospital, other providers, and medical insurance claims. I also authorize CRS to exchange information with DES or AHCCCS and other insurance companies as necessary to determine financial eligibility.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize any insurance company with whom I have coverage, to make payment directly to the hospital, clinic, physician or other CRS provider rendering service. I also agree to forward any insurance moneys, received for services rendered through Children's Rehabilitative Services, to the provider of such service. I agree to send copies of all explanation of benefits received by me from my health insurance company to CRS or CRS providers.

I agree that I have been deemed eligible for CRS services at 100% based on AHCCCS rates with insurance and will be responsible for any co-pays required of me by my insurance company. Initials:_____

I certify that I have read this agreement, received a copy, and am authorized to act for the member and as his or her parent to execute and accept the terms, conditions and authorizations set out above.

Expiration Date _____

Financially Responsible Person_____ Date _____

CRS Financial Staff _____ Date of Agreement_____

STATE ONLY

Family Gross Income	Family Total Deductions	Family Size
Revised: 11/02/06		

Attachment 2

Arizona Department of Health Services/ Office for Children with Special Health Care Needs
Children's Rehabilitative Services

ASSIGNMENT OF BENEFITS AGREEMENT FOR AHCCCS/KIDSCARE MEMBERS

Patient Name_____ **D.O.B.**_____

Does patient have Medical Insurance? Yes ☐ No ☐

I agree that any moneys received by me as a court award or settlement of a claim which provides for medical care of the member shall be used to pay CRS providers for care which is authorized and provided. I agree that when insurance benefits, court awards, claim settlements or other third party benefits are available, I shall make them available before CRS funds shall be used to provide care for the member or shall be used to reimburse CRS or the CRS contractor for all care provided to the member. If I receive and convert any benefits described by this subsection to my personal use and not for payment of the memberôs CRS services, I shall be personally responsible for the payment of the services for which the benefits were intended to pay.

I agree to provide all information necessary to enable CRS and CRS providers to collect such insurance. I agree to notify CRS within ten (10) days of any financial or insurance changes that would affect my financial eligibility.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize CRS to release information necessary for the completion of hospital, other providers, and medical insurance claims. I also authorize CRS to exchange information with DES or AHCCCS and other insurance companies as necessary to determine financial eligibility.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize any insurance company with whom I have coverage, to make payment directly to the hospital, clinic, physician or other CRS provider rendering service. I also agree to forward any insurance moneys, received for services rendered through Childrenôs Rehabilitative Services, to the provider of such service. I agree to send copies of all explanation of benefits received by me from my health insurance company to CRS or CRS providers.

I certify that I have read this agreement, received a copy, and am authorized to act for the member and as his or her parent to execute and accept the terms, conditions and authorizations set out above.

Expiration Date _____

Financially Responsible Person_____ Date _____

CRS Financial Staff _____ Date of Agreement_____

Effective: 11/02/06

Section 4.6 Applicant Eligibility Hearing Process

A. Applicant Rights

The CRS Contractor shall allow an applicant the right to:

1. A State Administrative Hearing for denial of enrollment in CRS.
2. Copies, at the applicant's expense, of any relevant document not protected from disclosure by law.

B. Who May File

1. An applicant in response to an adverse action taken by a CRS Contractor may request a State Administrative Hearing.
2. An authorized representative, including a provider, acting on behalf of the applicant, with the applicant's written consent, may request a State Administrative Hearing.

C. Time Frame for Requesting a Hearing

An applicant or authorized representative shall submit a written request for a State Administrative Hearing to ADHS/CRSA within thirty (30) days of receiving notification of denial of CRS enrollment. The request shall contain the applicant's name, the adverse action taken by a CRS Contractor, and the reason for the State Administrative Hearing request.

D. Notice of Hearing

1. ADHS/CRSA shall mail a Notice of Hearing under A.R.S. § 41-1092.05 if the request for a State Administrative Hearing is timely and contains the information listed below.
2. The Notice shall contain:
   a. A statement of time, place and nature of the hearing;
   b. A statement of the legal authority and jurisdiction under which the hearing is to be held;
   c. A reference to the statutes and rules involved;
   d. A short plain statement as to the matters in question; and
   e. The scheduled date for the hearing may be advanced or delayed in a showing of good cause or on agreement by the parties involved.

E. Notice of Hearing Decision

ADHS/CRSA shall mail a Decision to the applicant, member, or authorized representative no later than thirty (30) days after the date of the Administrative Law Judge's recommended decision.

F. Denial of a Request for a State Administrative Hearing

ADHS/CRSA shall deny a request for a State Administrative Hearing upon written determination if:

1. The request for a State Administrative Hearing is untimely;
2. The request for a State Administrative Hearing is not for an adverse action permitted under this policy;

3. The request for a State Administrative Hearing is moot based on the factual circumstances of the case; or
4. The sole issue presented is a federal or state law requiring an automatic change adversely affecting some or all applicants.

G. Withdrawal of a Request for a State Administrative Hearing

1. ADHS/CRSA shall accept a written request for withdrawal from the applicant, member, or authorized representative if a Notice of Hearing has not been mailed.
2. If ADHS/CRSA has mailed a Notice of Hearing, AHCCCS or ADHS/CRS shall forward the written request for withdrawal to the Office of Administrative Hearings (OAH).

H. Motion for Rehearing or Review

Under A.R.S. § 41-1092.09, ADHS (for non-Title XIX and non-Title XXI members) or AHCCCS (for Title XIX and Title XXI members) shall grant a rehearing or review for any of the following reasons materially affecting an applicant's or member's rights:

1. Irregularity in the proceedings of a State Administrative Hearing that deprived a petitioner of a fair hearing;
2. Misconduct of ADHS, AHCCCS, OAH, or a party;
3. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the hearing;
4. The decision is the result of passion or prejudice;
5. The decision is not justified by the evidence or is contrary to law; or
6. Good cause is established for the nonappearance of a party at the hearing.

Section 4.7 Re-determination of Member Payment Responsibility

A. CRS Contractor Request

At any time, the CRS Contractor may request a member or, if the member is a minor, the member's parent, to submit financial documents to re-determine the member payment responsibility for CRS services.

B. Member Request

At any time, a member or, if the member is a minor, the member's parent, may request a re-determination of the member payment responsibility by submitting to the CRS Contractor a written request for re-determination and any financial documents to assist with the re-determination process.

C. Contact Member

The CRS Contractor shall contact the member or parent within thirty (30) days from receipt of the member or parent request to re-determine the member payment responsibility to schedule a financial interview, if needed, or inform the member or parent of the new payment responsibility.

D. Re-determination of Member Payment Responsibility

The CRS Contractor shall re-determine the member payment responsibility every twelve (12) months as follows:

1. If the member has previously been identified as Title XIX/XXI, the CRS Contractor shall:
   a. Verify that the member remains Title XIX or Title XXI eligible;
   b. Provide the member a notice that informs the member that he/she remains eligible for CRS and includes a new CRS expiration date; and
   c. Not require a new member payment agreement.
2. If the member is not currently Title XIX/XXI eligible, the member, or member's parent if the member is a minor, will need to submit an AHCCCS application if potentially eligible and fill out a CRS financial application to determine the payment responsibility, unless the member agrees to pay 100% of the cost of CRS services.
3. If the member is classified as State Only and the adjusted gross income (gross income minus allowable deductions) of the member's household group is re-determined as equal to or greater than 200% of the FPL, the CRS Contractor shall:
   a. Notify the member or parent before forty-five (45) days of the CRS member's expiration date, if possible; and
   b. Require, within thirty (30) days of the notice, signature on a new Member Payment Agreement form indicating 100% payment responsibility for CRS services, unless the member payment responsibility was 100% pay prior to the re-determination.
4. If the member is classified as State Only and the adjusted gross income (gross income minus allowable deductions) of the member's household group is re-determined as less than 200% of the FPL, the CRS Contractor shall:

a. Notify the member or parent before forty-five (45) days of the CRS member's expiration date, if possible; and
b. Require, within thirty (30) days of the notice, signature on a new Member Payment Agreement form indicating 0% payment responsibility for CRS services, unless the member payment responsibility was 0% pay prior to the re-determination.

Section 4.8 Termination of CRS Enrollment

A. Allowable Reasons to Terminate CRS Enrollment

1. A CRS Contractor may terminate a member's enrollment in CRS if one of the following occurs:
   a. The CRS Contractor determines that the member no longer meets the medical and/or any of the non-medical eligibility requirements for CRS (age, residency, citizenship/qualified alien, and a CRS medical condition);
   b. The member does not apply for Title XIX/XXI within six (6) months of notification that a determination has been made by the CRS Contractor that the member is potentially eligible for enrollment in the program;
   c. A member who was enrolled in Title XIX/XXI does not remain enrolled while still eligible for Title XIX/XXI;
   d. The member or, if the member is a minor, the member's parent requests termination of CRS enrollment. (If the member is a Title XIX/XXI recipient and does not have third party insurance, the Contractor shall advise the member of the financial implications of termination and refer them to their AHCCCS Health Plan);
   e. A State Only member or, if the member is a minor, the member's parent, fails to comply with the signed Member Payment Agreement form or submission requirements, when applicable; or
   f. A State Only member or, if the member is a minor, the member's parent, fails to provide documentation or information requested by a CRS Contractor within defined timelines; or
   g. A State Only member, or parent if the member is a minor, does not complete a re-determination before the expiration date of the member's CRS enrollment.

B. Contractor's Actions

1. If a CRS Contractor terminates a member's enrollment in CRS, the CRS Contractor shall:
   a. Complete a CRS clinic patient discharge form and place it in the member's CRS medical record;
   b. Notify ADHS/CRSA of the member's termination via the eligibility update process;
   c. Send a written notice of termination to the member or, if the member is a child, a parent of the member, including the Hearing Rights as defined in Section 4.6; and
   d. Send a copy of the written notice of termination to the member's primary care provider, and AHCCCS Health Plan, if applicable.

Section 4.9 No-Show Appointments

A. No-Show Applicant Appointments

If an applicant fails to attend an initial medical evaluation appointment, the CRS Contractor shall follow these steps:

1. Contact the applicant/family by phone or letter to reschedule the appointment. If the applicant/family does not respond after two attempts to contact (with at least 48 hours between attempts), a letter must be sent to the applicant/family indicating that their CRS application will not be processed if the initial medical evaluation appointment is not rescheduled.
2. For a second missed appointment, follow the steps in 1. above. For applicants who are AHCCCS members, the AHCCCS Health Plan must be notified of the applicantôs no-shows for two scheduled initial medical evaluation appointments.
3. For a third missed appointment, the applicant/family and the AHCCCS Health Plan, if applicable, must be notified by letter of the termination of the application and the methods by which to re-apply.
4. CRS must document all attempts to contact the applicant/family.
5. If after any attempts made to contact the applicant there is no response within thirty (30) days, the CRS Contractor shall notify the applicant/family and the AHCCCS Health Plan of the termination of the application and the methods by which to re-apply.

B. No-Show Member Appointments

If a member fails to attend an appointment, the CRS Contractor shall follow these steps:

1. Per Section 4.8**,** Termination of Enrollment, the CRS Contractor cannot terminate a member for no-show appointments.
2. Contact the member/family by phone or letter to reschedule the appointment. If the member/family does not respond after two attempts to contact (with at least 48 hours between attempts), a letter must be sent to the member/family requesting to reschedule the appointment.
3. For a second missed appointment, follow the steps in A.1. above. For applicants who are AHCCCS members, the AHCCCS Health Plan must be notified of the memberôs no-shows for two scheduled appointments.
4. For a third missed appointment, the member/family and the AHCCCS Health Plan, if applicable, must be notified by letter that the member/family needs to contact the CRS clinic to reschedule the appointment or contact the CRS clinic to receive services.
5. If after any attempts to contact the member/family there is no response within thirty (30) days, the CRS Contractor shall provide notice to the member/family and the AHCCCS Health Plan that the member/family needs to contact the CRS clinic to reschedule an appointment.
6. If a CRS eligible member, who has no primary insurance or Medicare, refuses to receive CRS covered services through the CRS program, the CRS Contractor must send written notification to the member informing him or her that the member may be responsible to pay for those services received outside of the CRS program. The non-CRS provider may bill the member in accordance with AHCCCS regulations regarding billing for unauthorized services.
7. CRS must document all attempts to contact the member/family.

Section 5.1 CRS Covered & Excluded Conditions

A. Preface

CRS enrolls individuals who have specific medically handicapping or potentially handicapping conditions. This chapter defines the conditions that are covered and excluded by the CRS Program. CRS conditions are set forth in A.A.C. Title 9, Chapter 7, Article 2, Section 201.

B. General Philosophy

The philosophy of the CRS Program is based upon an individual's need for treatment of CRS conditions through medical, surgical, or therapy modalities where the following three criteria are present:

1. Specialized treatment is necessary;
2. Functional improvement is potentially achievable; and
3. Long-term follow-up may be required for maximum achievable results.

C. CRS Covered Conditions and Excluded Conditions

A CRS covered condition is a condition or disease that qualifies for treatment in the CRS program if other requirements are met. An excluded condition is not covered by CRS. The following section lists covered conditions and variations of the condition or related conditions that are excluded from coverage.

D. Cardiovascular System Conditions

1. Cardiovascular system conditions covered by CRS include the following:
   a. Congenital heart defects
   b. Cardiomyopathies,
   c. Valvular disorders,
   d. Arrhythmias,
   e. Conduction defects,
   f. Rheumatic heart disease that is not in the acute stage,
   g. Renal vascular hypertension, catecholamine hypertension,
   h. Arteriovenous fistulas, or
   i. Kawasaki Disease with evidence of coronary artery aneurysm, and
   j. Pectus Excavatum - if member demonstrates clinically significant functional impairment determined by standard pulmonary function and/or cardiac functioning tests, including EKG and echocardiogram, interpreted by a CRS pulmonologist and/or a CRS cardiologist.
2. The following cardiovascular conditions are excluded:
   a. Essential hypertension,
   b. Premature atrial, nodal, or ventricular contractions of no hemodynamic significance,
   c. Arteriovenous fistulas which may be a problem cosmetically, but do not cause cardiac failure or threaten loss of function, or
   d. Functional murmurs of no physiological significance, including peripheral pulmonic stenosis.

E. Endocrine System Conditions

1. Endocrine system conditions covered by CRS include the following:

a. Hypothyroidism,
b. Hyperthyroidism,
c. Adrenogenital syndromes,
d. Addison's Disease,
e. Hypoparathyroidism,
f. Hyperparathyroidism,
g. Diabetes Insipidus,
h. Cystic Fibrosis; and
i. Panhypopituitarism.

2. The following endocrine system conditions are excluded:
   a. Diabetes mellitus (includes treatment of diabetes mellitus in a member with cystic fibrosis),
   b. Isolated Growth Hormone Deficiency (Patients with panhypopituitarism, will receive growth hormone),
   c. Hypopituitarism encountered in the acute treatment of malignancies, and
   d. Precocious puberty, and
   e. Premature Thelarche.

F. Genitourinary System Conditions

1. Genitourinary system conditions covered by CRS include the following:
   a. Vesicoureteral reflux, with at least mild or moderate dilatation and tortuosity of the ureter and mild or moderate dilatation of renal pelvis,
   b. Ectopic ureter,
   c. Ambiguous genitalia,
   d. Ureteral stricture,
   e. Complex hypospadias,
   f. Hydronephrosis,
   g. Deformity and dysfunction of the genitourinary system secondary to trauma. Once the acute phase of the trauma has passed, CRS covers the corrective component of the deformity or dysfunction (see Section 5.2, G.),
   h. Pyelonephritis which has failed medical management and requires surgical intervention,
   i. Multicystic Dysplastic Kidneys,
   j. Nephritis associated with lupus erythematosis, or
   k. Hydrocele associated with ventriculo-peritoneal shunt.
2. The following genitourinary conditions are excluded:
   a. Nephritis, infectious or noninfectious, except when associated with lupus erythematosis,
   b. Nephrosis (nephrotic syndrome),
   c. Undescended testicle,
   d. Phimosis,
   e. Hydrocele, unless the hydrocele is associated with a ventriculo-peritoneal (VP) shunt,
   f. Enuresis, unless the enuresis is secondary to a CRS condition,
   g. Meatal Stenosis, or
   h. Simple hypospadias, defined as isolated glanular or coronal aberrant location of the urethral meatus without curvature of the penis.

G. Ear, Nose, and Throat Conditions

1. Ear, nose and throat conditions covered by CRS include the following:
    a. Cholesteatoma,
    b. Chronic mastoiditis,
    c. Deformity and dysfunction of the ear, nose, or throat secondary to trauma. Once the acute phase of the trauma has passed, CRS covers the corrective component of the deformity or dysfunction,
    d. Neurosensory hearing loss,
    e. Congenital malformations,
    f. Significant conductive hearing loss (greater than or equal to 30 decibels), one sided or bilateral, which despite medical treatment requires a hearing augmentation device (example: ossicular dysfunction),
    g. Otitis media in a child with cleft lip and palate or neurosensory hearing loss,
    h. Craniofacial anomalies that require multi-specialty, interdisciplinary treatments,
    i. Microtia that requires multiple surgical interventions, and
    j. Laryngeal Papillomatosis.
2. The following ear, nose, and throat conditions are excluded:
    a. Tonsillitis,
    b. Adenoiditis,
    c. Hypertrophic lingual frenum,
    d. Nasal polyps, except for members with cystic fibrosis,
    e. Cranial or Temporal Mandibular Joint Syndrome, simple deviated nasal septum,
    f. Recurrent otitis media without cleft lip and palate or without neurosensory hearing loss,
    g. Obstructive apnea,
    h. Acute perforations of the tympanic membrane,
    i. Sinusitis, except for members with cystic fibrosis,
    j. Isolated preauricular tags and/or pits, or
    k. Drooling and/or excessive salivation.

H. Musculoskeletal System Conditions

1. Musculoskeletal system conditions covered by CRS include the following:
    a. Osteochondrodysplasias, including:
        i. Achondroplasia,
        ii. Hypochondroplasia,
        iii. Diastrophic dysplasia,
        iv. Chondrodysplasia,
        v. Chondroectodermal dysplasias,
        vi. Spondyloepiphyseal dysplasia and variants,
        vii. Metaphyseal and epiphyseal dysplasias,
        viii. Larsen Syndrome,
        ix. Fibrous dysplasia,
        x. Osteogenesis imperfecta,
        xi. Rickets (all variants),

xii. Enchondromatosis, multiple cartilaginous, exostoses, single exostosis with evidence of functional impairment or rapid enlargement, or
xiii. Other osteochondrodysplasia as determined by CRS Medical Director review.

b. Juvenile rheumatoid arthritis and seronegative spondyloarthropathies,
c. Orthopedic complications of hemophilia,
d. Neuromuscular conditions, including:
   i. Myopathies,
   ii. Muscular dystrophies,
   iii. Myoneural disorders,
   iv. Arthrogryposis,
   v. Spinal muscle atrophy, or
   vi. Polyneuropathies, including Guillain Barré after the acute stage.
e. Bone and joint infections (chronic stage),
f. Upper limb malformations:
   i. Amputations, and
   ii. Syndactyly.
g. Spinal deformity, including:
   i. Kyphosis,
   ii. Scoliosis, or
   iii. Congenital spinal deformity with functional loss.

2. Cervical spine abnormalities, congenital and developmental,
3. Lower limb malformation,
   a. Hip dysplasia,
   b. Slipped capital femoral epiphysis,
   c. Femoral anteversion and tibial torsion that is:
      i. For an individual under eight years of age, associated with a neuromuscular disorder that is a CRS condition; or
      ii. For an individual eight years of age or older, causing significant functional impairment, as determined by CRS;
   d. Legg-Calve-Perthes Disease,
   e. Amputations, including prosthetic sequelae of cancer,
   f. Metatarsus adductus,
   g. Leg length discrepancy of 5 centimeters or more,
   h. Metatarsus primus varus,
   i. Dorsal bunions, and
   j. Complex bunions.
4. Collagen vascular diseases,
5. Benign bone tumors,
6. Deformity and dysfunction secondary to musculoskeletal trauma in a patient 15 years of age and younger at the time of initial injury, where the deformity and dysfunction is not in the acute phase (example: of three months duration. See Section 5.2, G.). Once the acute phase of the trauma has passed, CRS covers the corrective component of the deformity or dysfunction,
7. Osgood Schlatter's disease that has failed medical management, or
8. Complicated flat foot, defined as a rigid foot, unstable subtalar joint or significant calcaneus deformity.

9. The following musculoskeletal conditions are excluded:
    a. Ingrown toenails, unless secondary to a CRS condition,
    b. Back pain with no structural abnormalities,
    c. Ganglion cysts,
    d. Uncomplicated flat foot,
    e. Fractures except in cases where the fracture is caused by the CRS condition, and treatment is part of the CRS condition,
    f. Popliteal cysts,
    g. Femoral anteversion and tibial torsion, unless
        i. Associated with a neuromuscular disorder when the individual is under 8 years of age; or
        ii. The individual is 8 years of age or older and has significant functional impairment,
    h. Simple bunions, unless secondary to the CRS condition, or
    i. Carpal Tunnel Syndrome, unless secondary to the CRS condition.

I. Gastrointestinal System Conditions

1. Gastrointestinal system conditions covered by CRS include the following:
    a. Tracheoesophageal fistula,
    b. Anorectal atresia,
    c. Hirschsprungs Disease,
    d. Diaphragmatic hernia,
    e. Gastroesophageal reflux which has failed medical management and requires surgical intervention,
    f. Deformity and dysfunction of the gastrointestinal system secondary to trauma. Once the acute phase of the trauma has passed, CRS covers the corrective component of the deformity or dysfunction (See Section 5.2, G.),
    g. Biliary atresia,
    h. Congenital atresia, stenosis, fistuli, or rotational abnormalities of the gastrointestinal tract,
    i. Cleft lip and cleft palate (either or both conditions may be present),
    j. Other congenital malformations of the gastrointestinal tract:
        i. Omphalocele, or
        ii. Gastroschisis.
2. The following gastrointestinal conditions are excluded:
    a. Malabsorption Syndrome (Short Bowel Syndrome), except for members with cystic fibrosis,
    b. Crohn's Disease,
    c. Hernias except for diaphragmatic hernia,
    d. Ulcer disease,
    e. Ulcerative colitis,
    f. Intestinal polyps,
    g. Pyloric Stenosis, or
    h. Celiac Disease.

J. Nervous System Conditions

1. Nervous system conditions covered by CRS include the following:

a. Uncontrolled seizure disorders, where there have been more than two seizures with documented adequate blood levels of one or more medications,
b. Simple or controlled seizure disorders are covered when the child has no other health insurance. AHCCCS/KidsCare/private insurance eligible individuals will be treated through those provider networks,
c. Cerebral Palsy,
d. Muscular dystrophies or other myopathies,
e. Myoneural disorders,
f. Neuropathies (hereditary and idiopathic),
g. Central nervous system degenerative diseases,
h. Central nervous system malformations and structural abnormalities,
i. Hydrocephalus,
j. Craniosynostosis in a child less than 18 months of age of sagittal sutures, or unilateral coronal sutures, or multiple sutures,
k. Myasthenia gravis, congenital, or acquired,
l. Benign intracranial tumor,
m. Benign intraspinal tumor,
n. Tourette's Syndrome,
o. Residual dysfunction after resolution of an acute phase of vascular accident, inflammatory condition, or infection of the central nervous system,
p. Myelomeningocele (Spina Bifida),
q. Neurofibromatosis,
r. Deformity and dysfunction secondary to trauma in a patient 15 years of age and under at the time of the initial injury. Once the acute phase of the trauma has passed (acute phase includes acute rehabilitation), CRS covers the corrective component of the deformity or dysfunction (See Section 5.2, G.),
s. Sequelae of near drowning, after the acute phase, or
t. Sequelae of spinal cord injury, after the acute phase.

2. The following nervous system conditions are excluded:
   a. Headaches,
   b. Suspected seizure disorder,
   c. Central apnea secondary to prematurity,
   d. Near Sudden Infant Death Syndrome,
   e. Febrile seizures,
   f. Occipital plagiocephaly, either positional or secondary to lambdoidal synostosis,
   g. Trigonocephaly secondary to isolated metopic synostosis,
   h. Spina bifida occulta,
   i. Near drowning in the acute phase, or
   j. Spinal cord injury in the acute phase.

K. Ophthalmologic Conditions

1. Ophthalmological conditions covered by CRS include the following:
   a. Cataracts,
   b. Glaucoma,

c. Disorders of the optic nerve,
d. Non-malignant enucleation and post-enucleation reconstruction,
e. Retinopathy of prematurity,
f. Disorders of the iris, ciliary bodies, retina, lens, or cornea,
g. Simple refractive error and astigmatism for the above conditions, or
h. Ocular prosthesis. CRS will pay for the ocular prostheses, surgery, and orthotics related to the facial surgery.

2. The following ophthalmologic conditions are excluded:
   a. Simple refraction error, except for members with an eligible ophthalmologic condition,
   b. Astigmatism, except for members with an eligible ophthalmologic condition,
   c. Strabismus (with the exception of children with cerebral palsy, myelomeningocele, shunts and specific CRS eligible ophthalmologic disorders),
   d. Ptosis, or
   e. Cortical Blindness.

L. Respiratory System Conditions

1. Respiratory system conditions covered by CRS include the following:
   a. Anomalies of the larynx, trachea, and bronchi that require surgery,
   b. Nonmalignant obstructive lesions of the larynx, trachea and bronchi.
2. The following respiratory system conditions are excluded:
   a. Respiratory distress syndrome,
   b. Asthma,
   c. Allergies,
   d. Bronchopulmonary dysplasia,
   e. Emphysema,
   f. Chronic Obstructive Pulmonary Disease, or
   g. Acute or chronic respiratory care for the neuromuscularly impaired.

M. Integumentary System Conditions

1. Integumentary system conditions covered by CRS include the following:
   a. Craniofacial anomalies that require multispecialty interdisciplinary treatment,
   b. Burn scars where the burn scar is functionally limiting,
   c. Complicated nevi requiring staged procedures,
   d. Hemangioma where the hemangioma is functionally limiting, and
   e. Cystic hygroma.
2. The following integumentary conditions are excluded:
   a. Deformities without limitations to activities of daily living,
   b. Simple nevi,
   c. Skin tags,
   d. Port wine stain,
   e. Craniofacial anomalies with cosmetic considerations only,
   f. Sebaceous cysts,
   g. Isolated malocclusions (without documented functional loss),
   h. Pilonidal cysts, or

i. Ectodermal dysplasia.

N. Genetic and Metabolic Conditions

1. Genetic and metabolic conditions covered by CRS include the following:
   a. Amino acid and organic acidopathies,
   b. Inborn errors of metabolism,
   c. Storage diseases,
2. Metabolic conditions ascertained through the Arizona Newborn Screening Program:
   a. Phenylketonuria,
   b. Galactosemia,
   c. Homocystinuria,
   d. Hypothyroidism,
   e. Maple syrup urine disease,
   f. Biotinidase deficiency, or
   g. If the Arizona Newborn Screening Program adds other metabolic conditions to the screening panel, the CRS Program will apply for additional funding through the legislative budget process to cover the treatment of the added conditions.

O. Hematologic Conditions

Hematologic system conditions covered by CRS include the following:

1. Sickle cell anemia and other hemoglobinopathies,
2. Pre and postoperative iron deficiency anemia incurred as a result of a CRS condition.

P. A Medical Condition, Other Than One of the Conditions Listed Above, as Determined by a CRS Contractor Medical Director

1. Requires specialized treatment similar to the type and quantity of treatment a covered medical condition in sections A. through O. requires,
2. Is as likely to result in functional improvement with treatment as a covered medical condition in sections A. through O., and
3. Requires long-term follow-up of the type and quantity required for a covered medical condition listed in sections A. through O.

Section 5.2 Other Excluded Conditions or Services

This section specifies other conditions or services excluded from coverage in the CRS Program.

A. Allergies

Allergies are excluded.

B. Eating Disorders and Obesity

Eating disorders, including anorexia, bulimia, and obesity are excluded.

C. Autism

Autism is excluded.

D. Burns

Burns are excluded. However, a burn scar that limits function or movement may be a CRS condition (see Integumentary System Conditions, Section 5.1, M.

E. Cancer/Oncology

Cancer/oncology is excluded.

F. Chronic Vegetative State or Profound Mental Retardation

A chronic vegetative state or profound mental retardation is excluded as a primary diagnosis. These conditions are characterized by little or no interaction with the environment and little or no likelihood of functional improvement.

G. Deformity and Dysfunction Secondary to Trauma or Injury

Coverage of deformity and dysfunction secondary to trauma or injury is limited to children who are 15 years of age and under at the time of the initial injury. The deformity or dysfunction must have passed the acute phase (at least 3 months must have passed since the injury or trauma incident).

H. Dental and Orthodontia Services

1. Dental services are excluded, except for treatment of CRS members with the following conditions:
   a. Cleft lip or cleft palate,
   b. Documented significant functional malocclusion,
   c. Cardiac conditions where the member is at risk for subacute bacterial endocarditis,
   d. Cerebral spinal fluid diversion shunt where the CRS member is at risk for subacute bacterial endocarditis, or
   e. Dental complications arising as a result of treatment for a CRS condition.
2. Orthodontia services are excluded, except for treatment of CRS members with the following conditions:
   a. Cleft palate, or
   b. Documented significant functional malocclusion.

I. Depression or Other Mental Illness

Depression or other mental illness is excluded unless the depression or other mental illness is secondary to a CRS condition. If the depression or other mental illness is related to a CRS condition, a therapeutic trial of medication is allowed. Individuals should be referred to an appropriate agency for ongoing treatment.

J. Developmental Delay

Developmental delay is excluded.

K. Dyslexia/Learning Disabilities

Dyslexia and other learning disabilities, educational handicaps, minimal cerebral dysfunction, and behavioral problems are excluded.

L. Failure to Thrive

Failure to thrive is excluded.

M. Hyperactivity

Hyperactivity, including Attention Deficit Disorder, is excluded.

N. Ilizarov for Leg Lengthening

Ilizarov for leg lengthening is excluded, except when there is a presence of, or predicted, leg length discrepancy of greater than, or equal to five (5) centimeters at skeletal maturity.

O. Immunodeficiency

Immunodeficiency is excluded. Immunodeficiency includes conditions such as:

1. HIV (Human Immunodeficiency Virus)
2. AIDS (Acquired Immune Deficiency Syndrome)

P. Inpatient and Subacute Rehabilitation Services

Inpatient rehabilitation services and subacute rehabilitation services are not covered in the CRS program.

Section 6.1 Scope of Services

A. Preface

The Arizona Children's Rehabilitative Services (CRS) Program provides for medical treatment, rehabilitation, and related support services to qualified individuals who have certain medical, handicapping, or potentially handicapping conditions as defined in A.A.C. R9-7-202.

CRS accepts eligible applicants who require treatment for medical conditions that are conducive to treatment in clinic-based multi-specialty/interdisciplinary settings or in designated centers of excellence where specialized treatment is necessary, functional improvement is potentially achievable, and long-term follow-up may be required for maximum achievable results. Chapter 5.0 outlines CRS covered and excluded conditions. CRS provides services to enrolled members who meet the qualifications of the program. Chapter 4.0, Enrollment Requirements, outlines other requirements. CRS provides services through service contracts where the approach to service delivery is family-centered, coordinated, culturally competent, and considers the unique medical holistic needs of eligible persons. The policies included in this chapter delineate the provisions for rendering CRS services.

B. Scope of Services

The CRS Program provides covered medical, surgical, or therapy modalities for enrolled members. The CRS Program provides specialty services for CRS eligible conditions. Other health insurance plans, third party payors, or the individual pay for routine, preventative, or acute medical care needs.

C. CRS Contractors Providing Non-Covered Services

Service restrictions, exclusions, or prior authorization requirements do not apply if a CRS Contractor elects to provide non-covered services. Costs associated with providing non-covered services shall not be included in costs used to develop contractor reimbursement rates. A CRS Contractor shall use other funds to cover any costs of providing non-covered services.

D. CRS Service Requirements

CRS Contractors provide services to members if the service is:

1. Medically necessary;
2. Related to the CRS condition;
3. Provided consistent with utilization management practices.

Section 6.2 CRS Medical Services

CRS Contractors or authorized subcontractors provide CRS services in both inpatient and outpatient settings, such as contracted hospitals, CRS Clinics, and community based outreach clinics.

This section provides detailed information on the types of services provided by the CRS Program to treat CRS conditions. Included are any restrictions and exclusions for the services. Certain services may be available only in limited types of service settings or may be medically appropriate only for certain age groups or for individuals with a particular clinical presentation. Services may require prior authorization from the CRS Contractors and may require additional documentation to justify the medical necessity of the service for treating the CRS condition. Unless otherwise specified, coverage limits for services are per event.

A. Audiology Services

1. Covered Services:
   CRS provides covered audiology services to CRS members who are hearing impaired or whose CRS condition poses a risk for hearing impairment. Audiology services include:
   a. Audiologic Assessments
      i. Audiologic assessments shall be consistent with accepted standards of audiologic practice.
      ii. CRS may provide Brainstem Audiology Evoked Response (BAER) evaluations at the request of the CRS physician.
   b. Hearing Aid Fittings and Evaluations
      i. Hearing aids are provided for CRS members. The member may have the hearing aid reevaluated annually at the CRS clinic.
      ii. A hearing aid may be replaced once every three years, unless the member experiences a change in hearing levels or is determined by a CRS contracted audiologist to require a hearing aid replacement.
      iii. Replacement of lost hearing aids is limited to one replacement per 12-month period.
      iv. Implantable bone conduction devices are covered.
      v. Tactile hearing aids are covered for CRS members.
      vi. Cochlear implants are covered.
2. Exclusions and limitations:
   Accessory items are excluded. Only items necessary for proper functioning and maintenance of the hearing aid are included.
3. Contractor Requirements:
   The Contractor shall:
   a. provide an audiology area with the following:
      i. an audiometric testing suite containing at least one sound booth (6ô x 6ôminimum):
      ii. each sound booth shall be equipped with two sufficient ohm loud speakers that are mounted 6' apart at 45 or 90 degrees azimuth and

iii. one two-channel pure-tone (air and bone conduction) audiometer per sound booth having masking capabilities and speech capabilities (both for recorded and monitored live voice stimuli) and able to generate warble tones and/or narrow band noise stimuli for sound field testing.
iv. dedicated space for a hearing aid laboratory.

b. provide the following audiology equipment/supplies:
i. speech (recorded and live voice) stimuli test materials;
ii. a diagnostic impedance bridge;
iii. materials with capabilities for visual reinforcement and conditioned play;
iv. one halogen lamp otoscope with assorted ear tips for each sound booth;
v. one electroacoustic hearing aid analyzer and an assortment of earmold and hearing aid servicing tools, supplies and equipment;
vi. availability of hearing aids from various manufacturers, in order to meet the needs of each member; and
vii. a diagnostic Auditory Brainstem Response (ABR) unit for use on site. Appropriately licensed staff shall be provided to administer sedation and monitor members requiring sedation for ABR testing. A bed and a quiet room shall be available for ABR testing.

B. Dental and Orthodontia Services

1. Covered Services

a. Dental Services

CRS provides a full range of dental services only to enrolled members who have one of the following diagnosed conditions or circumstances:

i. Cleft lip and/or cleft palate,
ii. A cerebral spinal fluid diversion shunt where the member is at risk for subacute bacterial endocarditis,
iii. A cardiac condition where the member is at risk for subacute bacterial endocarditis,
iv. Dental complications arising as a result of treatment for a CRS condition, or
v. Documented significant functional malocclusion where malocclusion is defined as functionally impairing in a member with a craniofacial anomaly (e.g., hemifacial microsomia, Treacher Collins Syndrome) or when one of the following criteria is present:
Masticatory and swallowing abnormalities affect the nutritional status of the individual resulting in growth abnormalities,
1) The malocclusion induces clinically significant respiratory problems such as dynamic or static airway obstruction, or
2) Serious verbal communication disturbance as determined by a CRS contracted speech therapist. Report must indicate the malocclusion as the primary etiology for the speech impairment and that speech cannot be further improved by the speech therapy alone.

b. Orthodontia Services

Orthodontia services are covered for a member with a diagnosis of cleft palate or documented significant functional malocclusion.

2. Exclusions and Limitations
   a. Dental and orthodontia services may be provided in CRS clinics. When services are limited or in communities where there is no CRS clinic; the dental and orthodontia services may be provided at the CRS practitioner's private office.

C. Diagnostic Testing and Laboratory Services

1. Covered Services

   CRS Contractors shall provide member access to the following laboratory and diagnostic testing services:
   a. A full service laboratory including blood bank, pulmonary function, micro processing, testing with STAT capability, including phlebotomy and blood specimen preparation services, as well as equipment for performing CBCs and urinalysis.
   b. A full service general radiographic unit in or adjacent to the outpatient clinic.
   c. Special diagnostic testing services including: visual evoked response, CT scan, ultrasound, brainstem auditory evoked response (BAER), magnetic resonance imaging (MRI), electroencephalogram (EEG), electrocardiogram (EKG), and echocardiogram.
2. Exclusions and Limitations
   a. Diagnostic Testing

      Diagnostic testing is a covered service when specifically used to test for additional CRS conditions or to make treatment-planning decisions.
   b. Laboratory Services

      Follow-up laboratory evaluations where discovered laboratory abnormalities are unrelated to the CRS condition are excluded. The individual must be referred to his or her primary care physician for follow-up care. For example, an applicant is found to have sickle cell anemia, a CRS condition, but is also human immunodeficiency virus (HIV) positive. Follow-up care for the HIV status must be referred to the individual's primary care physician.

D. Durable Medical Equipment

1. Covered Services
   a. Medically necessary durable medical equipment is provided to the member for the purpose of rehabilitative care that is directly related to treatment for a CRS condition.
   b. Equipment repairs are covered when medically necessary.
   c. CRS covers equipment modifications that are medically necessary.
   d. Oxygen therapy for up to thirty (30) calendar days shall be covered when ordered by a CRS physician for the treatment of a CRS condition.
2. Exclusions and Limitations
   a. Members are eligible for equipment only when they are being followed in a medical or surgical CRS clinic. All equipment shall be directly related to the care of the CRS condition.

b. Equipment is covered only when an authorized CRS provider orders it.
c. Coverage is excluded for equipment used only for school purposes.
d. Oxygen and related supplies are limited to thirty (30) calendar days of coverage. Requests for extension may be submitted to the CRS Contractor's Medical Director or designee.
e. Coverage is excluded for the following items:
    i. Cranial modeling bands, except for members who are 24 months of age or younger who have undergone CRS approved cranial modeling surgery and demonstrate postoperative progressive loss of surgically achieved correction and that without intervention would most likely require additional remodeling surgery,
    ii. Mobilizer walker,
    iii. Motorized caster carts,
    iv. Motorized vehicles,
    v. Standers,
    vi. Strollers, except when used as modified seating for positioning, and
    vii. Toileting aids.

3. Equipment Maintenance

CRS does pay for equipment modifications necessary due to the member's growth or due to changes in the member's orthopedic or health needs. The CRS physician, the physical therapist, or occupational therapist shall recommend equipment modifications.

CRS does not pay for repairs needed because of improper use or neglect.

4. Equipment replacement or repair
    1. Contractors must have a contract clause with durable medical equipment (DME) providers, providing assurance that if an article furnished under the contract is found to be unsatisfactory due to imperfect or faulty construction within 60 calendar days of delivery, such articles shall be returned to the Contractor's provider to be corrected, adjusted, or replaced at no additional charge.
    2. A replacement for lost or stolen equipment shall be requested in writing to the CRS Medical Director or his/her designee. If the equipment was stolen, a copy of the police report, verifying the incident, must be submitted to the appropriate CRS clinic.
5. Wheelchairs and Ambulation Devices
    a. Covered Services
        i. CRS will provide and modify wheelchairs for CRS members, as well as provide ambulation assistive devices (crutches, canes, walkers).
        ii. CRS will provide wheelchair fittings, modifications, and repairs within 60 working days from the date ordered, from the date ordered by the member's provider.
        iii. CRS will provide final fittings for ambulation assistive/adaptive devices from the date ordered within:
            1) 20 working days for routine fittings.
            2) 5 working days for repairs ordered by a physician as "urgent."

3) same day service shall be provided for emergency adjustments or repairs for members unable to undertake their normal daily activities safely without the repair/adjustments.

iv.. CRS covers medically necessary equipment modifications due to member's growth or changes in the member's orthopedic or health needs.

v. Wheelchairs and ambulation devices are covered when:
1) There is a change in the member's medical condition,
2) The equipment is no longer safe to operate, or
3) The child has outgrown the equipment.

vi. Custom fit standers and parapodiums with click-clacks are covered for braced-walking potential for spinal cord defect patients.

vii. Trays for wheelchairs will be provided when documentation indicates that the need is directly related to improvement in functional skill level.

b. Exclusions and Limitations

i. CRS will not supply a member with a second non-power wheelchair or ambulation device if the member already has a wheelchair or ambulation device that is in good working order.

ii. Replacement of wheelchairs and ambulation devices is not a covered service when the equipment is functional and can be repaired such that the equipment is safe to operate.

iii. CRS does not pay for physical or structural modifications to a home.

iv. The CRS member's family or guardian shall be responsible for the care of and transportation of equipment.

v. The CRS member and/or his or her family shall demonstrate that they can safely use all equipment provided to the member. Practical and functional use of equipment shall be documented in the member's CRS medical record.

vi. Wheelchairs and ambulation devices used solely for school purposes are excluded.

vii. CRS may repair or provide maintenance of equipment that, although not provided to the member by CRS, a CRS provider has determined to be safe and appropriate.

viii. Wheelchair and ambulation device needs shall be met through recycled items, i.e., wheelchairs, if the item meets needed specifications.

ix. Short-term rental wheelchairs and ambulation devices are limited to thirty (30) calendar days. The CRS Medical Director or designee may approve requests for extension.

6. High Frequency Chest Wall Oscillation (HFCWO) Therapy

a. Criteria for medical necessity include, but are not limited to, all of the following:

i. Diagnosis of cystic fibrosis;

ii. Documentation of excessive sputum production combined with the member's inability to clear the sputum without assistance;
iii. Copy of chest x-ray report and pulmonary function tests showing findings consistent with moderate or severe chronic obstructive pulmonary disease (COPD);
iv. Prescription signed by M.D. or D.O. with a specialty in pulmonary disease, indicating the need for at least daily (or more frequent) chest physiotherapy;
v. Age 2 years or older or 20 inch chest size, whichever comes first;
vi. Specific documentation supporting why HFCWO therapy for the member is superior to other more cost-effective therapy methods, including at least one of the following:
    1) Promotes independent self-care for the individual;
    2) Allows independent living or university or college attendance for the individual;
    3) Provides stabilization in single adults or emancipated individuals without able partners to assist with CPT, or
    4) Sever end-stage lung disease requiring complex or frequent chest physiotherapy.
vii. Evidence that the member can use the vest effectively, including continuing compliance with all forms of prescribed therapy and treatment and member and family acceptance of HFCWO therapy; and
viii. Coordination between the provider office or clinic and Arizona Health Care Cost Containment System (AHCCCS) or other payer source, such as Arizona Department of Health Services (ADHS)/CRS or AHCCCS Contractor, prior to implementation of HFCWO therapy for long-term use.

b. Discontinuation Criteria for HFCWO
    i. Patient and/or prescribing physician request; or
    ii. Patient treatment compliance at a rate of less than 50% usage as prescribed in the medical treatment plan, to be checked at two (2) and six (6) months of usage.

c. HFCWO for Members Without Diagnosis of Cystic Fibrosis
HFCWO is a covered service for adult members (age 21 and older) who meet all of the above criteria for medical necessity (except for diagnosis of Cystic Fibrosis), but who have a diagnosis such as chronic bronchiectasis or alpha-1 antitrypsin deficiency where there is an acute exacerbation of the illness or the disease is in the terminal stages. AHCCCS Contractor Medical Directors, or the AHCCCS Medical Director for FFS members, shall perform a case-by-case review to determine that HFCWO therapy is superior to other, more cost effective, forms of therapy. Prior authorization is required.

E. Home Health Care Services

Home health care services include professional nurse visits, therapies, social work services, equipment, and medications.

1. Pre-hospitalization
   Home health care services are limited to pre-hospitalization for a procedure or surgery in lieu of hospitalization to provide total parenteral nutrition.
2. Post-hospitalization
   Home health care services are limited to the post-hospitalization rehabilitative or recovery period or are provided in lieu of hospitalization. Services must be ordered by the CRS Provider.
   Home health care services provided in a member's place of residence includes:
   a. Assessment of home health needs,
   b. IV therapies,
   c. Wound evaluation,
   d. Administration of medications,
   e. Monitoring vital signs,
   f. Monitoring oxygen administration,
   g. Monitoring and assessing patient physical signs,
   h. Teaching and evaluating of therapies,
   i. Enterstomal therapy and teaching,
   j. Catheter insertion, care, and teaching, and
   k. Instruction regarding home health care to member or member's caregivers.
3. Exclusions and limitations
   a. Home health care services must be ordered by the physician who is supervising the CRS care for the member.

F. Inpatient Services

CRS covers inpatient acute care hospitalization only for a CRS member at the CRS contracted provider sites. The hospitalization is covered for a member when the hospitalization is specifically for the treatment of a CRS condition.

1. Requirements for Admission and CRS Reimbursement for an Inpatient Acute Care Stay
   a. Only CRS physicians can admit and treat CRS members for CRS conditions. Physicians must have a contract with a CRS Contractor or be appropriately credentialed with a CRS Contractor to admit and treat CRS members.
   b. The admitting physician shall obtain prior authorization from the CRS Contractor for all non-emergency hospital CRS related admissions.
   c. Prior authorization is not required for an emergency admission that is related to a CRS condition.
   d. The primary reason for hospitalization shall be related to the CRS condition.
   e. CRS does not provide hospitalization for the sole purpose of maintaining the member, i.e., long-term ventilator support, nutritional support.
   f. See Section 11.0 for Discharge Planning.
2. Rule Out Ventricular Infection or Rule Out Ventricular Shunt Failure CRS will pay for the initial diagnostic evaluation by a CRS provider to rule out a ventricular infection or ventricular shunt failure at a CRS contractor hospital. The period of time covered for the rule out is from the time of admission until the results of the

CT scan, MRI, CFS culture, or measurements of ICP are available to the physician. If the member does not have a shunt infection or failure as described above, he or she must be decertified from CRS payor liability from the point of the neurosurgeon's diagnosis forward. The responsibility for hospitalization for the acute illness is transferred to the appropriate payor. CRS Contractor's utilization review staff coordinates the transition of care with other payors and related agencies.

G. Growth Hormone Therapy

CRS covers growth hormone therapy only for members with panhypopituitarism.

H. Nursing Services

Nursing services include:

1. Direct nursing care to members during specialty clinics and supervision of subordinate nursing staff during specialty clinics;
2. Documented nursing care assessments, interventions, implementation, and revisions of care following evaluation;
3. Education of members, families, caregivers, and other staff in treatment and testing procedures, health promotion, self-care skills, and anticipatory guidance; and
4. Discharge planning and care coordination services.

I. Nutrition Services

1. Covered Services

   Nutrition services include screening, assessment, intervention, and monitoring. CRS Contractors shall cover nutrition services for CRS members with special nutritional needs when the nutritional need is related to a CRS condition.
2. Exclusions and Limitations
   a. A registered dietitian must provide nutrition services.
   b. CRS does not cover total parenteral nutrition (TPN) for long-term nutrition. TPN services may be provided for a member in lieu of hospitalization for preparation of an authorized CRS surgery.
   c. CRS covers nutritional supplements upon referral from CRS physicians with consultation by a registered dietician in accordance with the following guidelines:
      i. Metabolic Disorders

         Formulas for metabolic disorders such as PKU, MSUD, HCU, and isovaleric acidemia that are treated by a special diet are covered based on the CRS Contractor's formulary or CRS Medical Director approval and in accordance with the following guidelines:
         1) PRODUCTS: Specified formulas for treatment of metabolic disorders such as Lofenalac, Phenyl-Free, Analog X, Maxamaid X, MSUD Diet Powder, and formula component products such as Mead Johnson Product 80056.
         2) QUANTITY: As needed, based upon demands for growth and maintenance, to be determined by the registered dietitian.
            a) DURATION: As long as treatment through dietary

modification continues, up to 21 years of age.

b) NOT COVERED: Lactose-free formulas for galactosemia; infant formulas or milk products used in con-junction with modified amino acid formulas; low protein food products such as pasta, breads, and cookies for amino acid disorders.

3) Tube Feedings

Tube feedings and medically necessary tube feeding equipment are available for CRS members when the need is related to a CRS condition.

a) PRODUCTS: Commercially available tube feeding formulas such as Compleat, Isocal, Osmolite, and formula component products such as Polycose.

b) QUANTITY: As needed, based upon demands for growth and maintenance, to be determined by the physician or registered dietitian.

c) DURATION: Limited to thirty (30) calendar days of coverage. The CRS Medical Director or designee must approve extension for cover-age.

d) EQUIPMENT: Tube feeding equipment, such as feeding pumps, will be provided by CRS when deemed medically necessary to provide adequate nutrition.

e) NOT COVERED: Foods and beverages recom-mended for blenderized recipes.

4) Cystic Fibrosis

Nutrition services are available for CRS members with cystic fibrosis when appropriate growth and maintenance requires a supplemental product and no other resources or community nutrition support programs are available.

a) PRODUCTS: Commercially available nutrition supplements for additional calories and other nutrients. Examples include Ensure, Enrich, Sustacal, and formula component products such as MCT oil. (Consult manufacturers' product hand-books for nutritional content.)

b) QUANTITY: Limited to approximately 50 percent of daily caloric needs for infants, individuals, and adults as a supplement to a regular diet unless the cystic fibrosis individual is also being tube fed (see 2 above).

c) DURATION: Limited to thirty (30) calendar days of coverage. The CRS Medical Director or designee must approve extension for cover-age.

d) NOT COVERED: Foods and beverages that constitute the member's regular diet.

J. Outpatient Services

1. Covered Services

   Covered outpatient services include:

   a. Ambulatory surgery,
   b. Outpatient diagnostic and laboratory services,
   c. Ancillary services,
   d. Emergency room services, and
   e. Clinic Services.
      i. Multi-specialty, Interdisciplinary Clinics
         1) CRS members may require multi-specialty, interdisciplinary teams of care. The CRS Program and CRS Contractors develop and provide the availability of these teams throughout the state to the greatest extent possible, within the limits of appropriated funds.
         2) Members cannot enter the program directly into a specialty clinic without an assessment and evaluation from the CRS Medical Director or designee who is authorized to determine medical eligibility.
         3) CRS Specialty Clinics may include but are not limited to:
            a) Amputee,
            b) Arthritis/rheumatology,
            c) Cardiac,
            d) Cystic fibrosis,
            e) ENT,
            f) Endocrine,
            g) Eye,
            h) Genetics,
            i) Hand,
            j) Myelomeningocele,
            k) Neurofibromatosis,
            l) Neurology,
            m) Neurosurgery,
            n) Nutrition,
            o) Orthodontia,
            p) Orthopedics
            q) Cerebral palsy,
            r) Plastic surgery,
            s) Pulmonary,
            t) Rhizotomy,
            u) Scoliosis,
            v) Sickle cell anemia,
            w) Urology,
            x) General surgery,
            y) Feeding,
            z) Wheelchair, and
            aa) Metabolic.
      ii. Community-Based Field Clinics
         1) CRSA develops field clinics where the demand exists and resources are available. Community-based field clinics are

specialty clinics that are held periodically in locations other than the CRS Contractorsônormal clinic locations such as in outlying towns and communities in Arizona, or on Indian Reservations.

2) Outreach clinics may include:
   a) Cardiac,
   b) Orthopedic,
   c) Genetic,
   d) Neurology,
   e) Plastic Surgery, and
   f) Ear, Nose, and Throat (ENT).

2. Limitations

The memberôs primary health care system must be used for routine and acute medical care that is not related to the CRS condition, such as periodic visits for scheduled immunizations and periodic physical examinations and check-ups.

K. Pharmaceuticals

1. Covered Services:

Pharmaceuticals are covered when appropriate to the treatment of the CRS condition when ordered by the CRS physician and when provided through a contracted pharmacy. Covered services also include special formulation nutrition needs for metabolic patients. See Section I., Nutrition Services, above.

a. Exclusions and Limitations
   i. Pharmaceuticals or supplies that would normally be ordered by the primary care physician for the overall health maintenance of the individual are not covered (i.e., multiple vitamins).
   ii. Cerezyme for the treatment of Gaucherôs Disease covered by catastrophic reinsurance under Arizona Health Care Cost Containment System (AHCCCS) for Title XIX and Title XXI members is not covered by CRS.
   iii. Medications covered under Medicare Part D for CRS members who are dual eligible (AHCCCS/Medicare) enrollees are not covered by CRS.

b. CRS Contractors are required to provide a pharmacy location either in the CRS Contractorôs clinic area or as approved by CRS.

c. CRSA shall maintain a statewide formulary that may be changed through change submissions to the CRSA Medical Director.

d. Exceptions to the formulary may be made under special circumstances when approved by a Contractorôs Medical Director following the contractorôs policy and procedure.

L. Physical and Occupational Therapy Services

Physical and occupational therapy services must be related to the memberôs CRS condition.

1. Covered services:

a. Physical therapy and occupational therapy are provided when the member is unable to obtain physical therapy or occupational therapy through a source other than CRS, and

b. The member has a strong potential for rehabilitation as determined by a CRS provider.

M. Physician Services

Physician services shall be furnished by a licensed physician and shall be covered for members when rendered within the physician's scope of practice under A.R.S Title 32. A physician shall be a member of a CRS contracted facility's professional staff and shall be appropriately credentialed. CRS Contractors are responsible for contracting with physician specialists with expertise in pediatrics to provide CRS services. Medically necessary physician services may be provided in an inpatient or outpatient setting, and shall include:

1. Medical evaluations, consultation, and diagnostic workups,
2. Medically necessary treatment for the CRS condition,
3. Prescriptions for medications, supplies and equipment,
4. Referrals to other specialists or health care professionals when necessary, and
5. Patient education.

N. Prosthetic and Orthotic Devices

1. Covered Services
   a. Prosthetic and orthotic devices are provided to a member to enhance the member's ability for perform activities of daily living.
   b. CRS covers prosthetic and orthotic modifications or repairs which are medically necessary because of the individual's growth or due to changes in the individual's orthopedic or health needs or when equipment is no longer safe.
   c. CRS covers ocular prostheses and replacements when related to a CRS condition. CRS also provides and replaces ocular prostheses for CRS members when medically necessary.
   d. A replacement for lost or stolen prosthetic and orthotic devices shall be requested in writing to the CRS Medical Director or designee. If the device was stolen, a copy of the police report, verifying the incident, must be submitted to the appropriate CRS clinic.
   e. CRS shall provide or fabricate orthotic/prothetic devices that assist CRS members in performing normal living activities and skills, such as:
      i. all orthotic/prosthetic devices shall be constructed or fabricated using high quality products;
      ii. all orthotics shall be completed, modified or repaired and delivered to the CRS member within 15 working days of the provider's order;
      iii. all prosthetics shall be completed, modified or repaired and delivered to the CRS member within 20 working days following the member's provider order;
      iv. orthotic/prosthetic repairs ordered by physician as "urgent" shall be delivered within 5 working days; and
      v. same day service shall be provided for emergency adjustments for members unable to undertake their normal daily activities without the repairs and/or modifications.
   f. CRS will assure there will be no additional charge for modifications and/or

repairs during the normal life expectancy of the device except as required to accommodate a documented change in the member's physical size, functional level, or medical condition.

2. Exclusions and Limitations
   a. Myoelectric protheses are excluded.
   b. Shoes are excluded.
   c. Repair or replacement required due to misuse by the member is excluded.

O. Psychology and Psychiatry Services

1. Psychology Services
   a. Covered Services
      i. Covered psychology services include short-term crisis intervention, assessment, evaluation, and referral to other services.
      ii. A state licensed psychologist must provide psychology services.
   b. Exclusions and Limitations
      i. Psychology services for CRS members and their families require a referral from the CRS physician or professional staff.
      ii. Psychology services are limited to three (3) visits per calendar year, and must be related to the member's CRS condition. Additional psychology visits may be covered when approved by the CRS Medical Director or designee. CRS does not provide ongoing psychological counseling or services.
2. Psychiatry Services
   a. Covered Services
      CRS provides psychiatry services to CRS members upon evaluation and referral by a CRS psychologist.
   b. Exclusions and Limitations
      i. Psychiatry services are limited to one (1) visit per calendar year, and must be related to the member's CRS condition.
      ii. Additional visits may be covered when approved by the CRS Medical Director or designee.

P. Second Opinions

1. Covered Services
   CRS covers second opinions by other CRS contracted physicians when available. If not available, CRS will provide a second opinion by a non CRS contracted physician.
2. Exclusions and Limitations
   a. Only one-second opinion is allowed per episode or specialty.
   b. Second opinion visits will be provided at the first available appointment.
   c. Office visits for second opinions may be arranged on an urgent basis at the discretion of the home site contractor.
3. Each CRS Contractor shall be responsible for developing its own internal procedures for processing second opinion requests.

Q. Speech Therapy Services

Speech therapy services must be related to the member's CRS condition.

1. Covered Services
   a. Speech therapy is provided when the member is unable to obtain speech therapy through a source other than CRS, and
   b. The member has a strong potential for rehabilitation as determined by a CRS provider.

R. Transplants

1. Covered services
   CRS covers transplant services for corneal transplants and incidental bone grafting transplants.
2. Exclusions and Limitations
   Cardiac, organ and bone marrow transplants are excluded.

S. Vision Services

1. Covered Services
   Vision services include examinations, eyeglasses, and contact lenses for the treatment of a CRS condition.
2. Exclusions and Limitations
   Replacements for broken or lost glasses or contact lenses are limited to one replacement per prescription per calendar year.
   Lens enhancements such as ultra violet (UV) tinting and safety glass shall be provided as medically necessary and ordered by a CRS physician.

Section 6.3 Family-Centered and Culturally Competent Services

A. Advocacy Services

1. CRS provides advocacy services for CRS applicants, members, and families. Advocates assist applicants, members, and families to understand and access medical organizational systems community and public resources, and assists in the resolution or prevention of problems regarding CRS services. An advocate may act as a liaison between clinic staff, educators, physicians, therapists, nurses, nutritionists, other professionals, family members, and the child to prevent or resolve problems. Advocacy services include:
    a. Assisting members and their families in interpreting and understanding information so that members and their families can make informed decisions about the member's care,
    b. Educational resources and support for the member and family,
    c. Education of families about advocacy so that they will be empowered to act as their own advocate,
    d. Education of health care professionals in principles of family-centered care,
    e. Education of families regarding member rights and responsibilities related to the CRS program,
    f. Orientation of new members and their families, and
    g. Liaison between CRS clinic physicians, families, inpatient and outpatient staff, administrators, educators, and other professionals to prevent or resolve problems.
2. CRS Contractors may provide a patient advocate in the CRS Clinic to act as a liaison for families and CRS staff to resolve or prevent problems.
3. CRS Contractors shall assure that advocacy staff have a minimum of three (3) years experience and a Bachelor's Degree in health/human services, community/public relations, marketing or related fields, or equivalent demonstrated experience in customer relations and consumer advocacy.

B. Care Coordination Services

Care coordination services include:

1. Coordination of CRS health care through multi-specialty, interdisciplinary approach to care, and
2. Collaboration with external providers, including community agencies, service systems, other payor sources, members, and their families, i.e., referrals and program information.

C. Child Life Services

CRS provides child life services. Child life services include organization of individual, family, or group activities designed to reduce the member's and family's fear of the nature of the illness, medical care, and procedures. CRS Contractors may provide structured child life activities for hospitalized CRS members either in a playroom or at the bedside and in the outpatient clinic waiting room and/or play areas for individuals and siblings.

1. Child Life activities may include:
    a. Group activities of expressive play,

b. Pre-operative teaching and medical play designed to decrease fears while increasing understanding and confidence,
c. Explanations comprehensible to the child of sequence, nature, and reasons for procedures and routines, and
d. Support and coping strategies for the child during painful procedures.

2. Child Life Specialists must have a Bachelors degree in child life or a closely related field or equivalent and demonstrate experience in child life services. Individuals with Child Life Certification are preferred.

D. Education Services

CRS provides education services including:

1. Education of and assistance to members and their families. Provide information about care, services, support systems, and advocacy.
2. Education of members and their families about the history and prognosis of the CRS condition, treatment options even if the medical services are not covered by CRS, treatment planning, health risks, growth and development, transition planning, and offering of genetic counseling, when appropriate, regarding the condition.
3. Coordination with the schools, physicians, parents, and clinic staff regarding accommodation of a memberôs special educational needs.
4. Coordination with the educational system regarding the educational needs of CRS members for the purpose of establishing educational needs and goals for an inpatient stay or homebound program.
5. Public education of community groups and organizations, public health personnel, school personnel, health care providers, insurers, regional and national health organizations, and welfare services about the CRS program and its services.
6. Encouragement of teaching and research initiatives.
7. Education to physicians, health care professionals, and other individuals regarding the unique needs and concerns related to the care and treatment of children and young adults with special health care needs.

E. Family Centered Culturally Competent Care

CRS provides family-centered care in all aspects of its service delivery system. The responsibilities of the CRS Contractors in support of family-centered care include:

1. Recognizing the family as the primary source of support for the membersô health care decision-making process. Service systems and personnel are available to support the familyôs role as decision makers.
2. Facilitating collaboration among families, health care providers, and policymakers at all levels for the:
   a. Care of the member,
   b. Development, implementation, and evaluation of programs, and
   c. Policy development.
3. Promoting complete exchange of unbiased information between families and health care professionals in a supportive manner at all times.
4. Recognizing cultural, racial, ethnic, geographic, social, spiritual, and economic diversity and individuality within and across all families.
5. Implementing practices and policies that support the needs of families, including

medical, developmental, educational, emotional, environmental, and financial needs.

6. Administering a cultural competence self-assessment to all staff annually and provide results to CRSA.
7. Participating in CRSA Cultural Competency training modules.
8. Facilitating family-to-family support and networking.
9. Promoting available, accessible, and comprehensive community, home, and hospital support systems to meet diverse, unique needs of the family.
10. Appreciating and recognizing the unique nature of each family.

F. Individual and Family Rights and Responsibilities

1. Access to Care
   a. The member and family can expect impartial access to information, treatment, and accommodations that are available or medically indicated, regardless of race, color, creed, ethnicity, sex, age, religion, national origin, ancestry, marital status, sexual preference, genetic information, physical or cognitive disability, diagnosis, prognosis, or sources of payment for care.
   b. The member and family can expect services that are provided in a culturally competent manner with consideration for members with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds, visual and/or auditory limitations.
   c. The member and family can request to be seen in a CRS Clinic or by another physician.
   d. The member and family can request a second opinion at no cost to the family member.
   e. Members and families can be informed of medical alternatives and other types of care and how to access that care.
   f. Members and families can expect to be informed in writing of changes in services.
   g. Members and families can ask and be informed about how CRS pays providers and CRS bills.
   h. Members and families can request results of the CRS Family Satisfaction Survey.
2. Respect, Dignity, and Emotional Support
   The member and family have the right to receive considerate, respectful care with recognition of personal dignity and impartial access to emotional and spiritual support at all times and under all circumstances regardless of race, ethnicity, sex, national origin, diagnosis, prognosis, or sources of payment for care.
3. Privacy and Confidentiality
   a. The member and family have a right to expect every consideration of adequate personal and informational privacy.
   b. CRS Contractors must implement procedures to ensure the confidentiality of health and medical records and of other member information. Procedures need to:
      i. Be in compliance with all federal, state, and local requirements; and

ii. Include process for monitoring and ensuring compliance.

4. Identity
   Members have the right to know the identity of physicians, nurses, and others involved in their care. This includes students, residents, or other trainees providing care to CRS members.
5. Communication
   a. The member and family have a right to obtain complete and current information about diagnosis, treatment, and expectations for outcome from health care providers.
   b. The member and family have a right to formulate advance directives. Advance directives must be:
      1) In compliance with federal and state statutes and
      2) Be documented in writing in the member's medical record.
   c. Individuals, parents, and legal guardians shall have the right to access their own medical record in accordance with the record release policy specified in Section 9.2.
   d. CRS Contractors shall make every effort to ensure that all information prepared for distribution to members is written in an easily understood language and format.. Regardless of the format chosen, the CRS recipient information must be printed in a type, style and size that can be easily read by recipients with varying degrees of visual impairment. Members must be notified that alternative formats are available and how to access them.
   e. Receive translation/signer services free of charge and know about providers who speak languages other than English and how to get a free directory of CRS providers. All informational materials shall be reviewed for accuracy and approved by CRSA prior to distribution to recipients.
6. Growth and Development
   The member has the right to developmentally appropriate care and information with respect to the manner in which personnel speak and interact with them, choices of activities, and inclusion in decisions made about their care.
7. Grievance and Appeal Procedure
   a. The member and family have the right to voice dissatisfaction they have with the treatment or care the member receives and be free from any form of punishment restraint or seclusion for decisions and filing a complaint.
   b. Applicants, members, ex-members, parents, and legal representatives will be provided with information regarding how to voice complaints, file grievances, or appeals and request administrative hearings.
   c. Applicants, members, ex-members, parents, and legal representatives will be provided with information regarding expedited reviews.
   d. Members, parents, and legal representatives will be provided with information regarding continuation of reduced or denied services within thirty (30) days of enrollment or changes to the information (See Chapter 8.0 for Grievance/Appeal process).

G. Medical Home

CRS supports the concepts of medical home as defined by the American Academy of Pediatrics. These concepts include the following operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care. A Medical Home model ensures that each member has a Primary Care Provider (PCP) and that the membersôPCP is part of the interdisciplinary approach to care and the decision-making process.

H. Parent Action Council

Each CRS Contractor shall have a Parent Action Council (PAC). The PAC is a partnership between parents and the Contractor that is parent driven. The Contractor will actively participate in, and support PAC activities. Functions:

1. The PAC shall:
   a. Function as an active body to the Contractor and professionals involved in the program. The PAC shall participate in the development of policy and procedures that influence the delivery of services to children and families that use the CRS program.
   b. Develop an annual budget and budget committee with monies allocated from CRSA and monies collected by other means, and participate in decisions regarding how PAC funds are spent.
   c. Select two parent representatives to the State Parent Action Council (SPAC).
   d. Meet for a stated activity or meeting as determined by the members of the PAC.
2. The Contractor shall:
   a. Ensure CRS Contractor administrator or designee attendance at the PAC meetings or activity.
   b. Provide interpretation services at the meetings and activities. Provide translated written materials as requested by members of the PAC.
   c. Schedule meetings/activities and provide timely notification to potential participants.
3. Membership:
   a. The PAC shall consist of individuals, defined as family members, foster parents, or legal guardians of a child who is, or has been a CRS member, or adults who are or were CRS members, and the CRS contractor. PAC members may also include professionals and members of advocacy groups.
   b. Voting members of each PAC shall consist of individuals defined as family members, foster parents, or legal guardians of a child who is, or has been a CRS member, or adults who are or were CRS members.

I. Parent Involvement/PAC Fund

The Parent Involvement/Parent Action Council (PAC) Fund supports and promotes parent involvement within the CRS Program. The funds will be allocated annually at the beginning of the fiscal year. PAC Fund expenditure guidelines are as follows:

1. Reimbursement to parents for participation in CRS Clinic meetings, activities, and projects that influence service delivery to members and their families.
2. Reimbursement to parents for participation in PAC activities such as:
   a. Newsletter or information resource production;

b. Promotion of PAC;
c. Community liaison activities; and
d. PAC/Contractor committees, projects and activities.

3. Reimbursement for PAC operating expenses, approved by the PAC representation, such as:
   a. Mail-outs of PAC meeting notices, minutes, or newsletters;
   b. Costs of office supplies/services supporting PAC activities, paper, envelopes, printing, duplicating costs, and other technological supplies;
   c. Costs related to flyers, meeting notices, newsletter production;
   d. Not more than 20% of the PAC funds may be used for operating expenses. (If parent involvement is reimbursable though the contractor or other sources more than 20% of these funds may be used for operating expenses/supplies.);
   e. Per State policy, no food or beverage reimbursement is allowed, and:
   f. A PAC budget committee established at each CRS Contractor facility must approve PAC expenditures.
4. To receive reimbursement, expenditures made by CRS Contractors must be documented. Contractors should keep original receipts on file should CRSA request to review the substantiating information. Copies of the documentation and an original Contractor's Expenditure Report (CER), as provided by CRSA, must be mailed to CRSA annually at a minimum.

J. Pediatric to Adult Transition Services

For CRS members who are transitioning to adult services, the CRS Contractor shall initiate a transition plan by the age of fourteen (14) years which is ongoing until the member leaves the CRS program. The transition plan shall:

1. Establish a plan that is age appropriate and addresses the current transition needs of the member (i.e. education, social and emotional health, guardianship, transportation, developmental and functional independence, health condition management)
2. Ensure families, members, and their primary care providers are part of the development and implementation of the transition plan;
3. Document the transition plan in the medical record;
4. Establish a timeline for completing all services the member should receive through CRS prior to his or her twenty-first birthday;
5. Review and update the plan and timeline with member and family prior to official transition to adult provider;
6. Advise the member's primary care provider of the discharge and ensure coordination of the services with the adult primary care provider;
7. Coordinate the transition plan with the appropriate:
   a. AHCCCS health plan;
   b. ALTCS program contractors;
   c. IHS/638 and tribal entities upon discharge from a CRS clinic and/or discharge from the CRS program; and
   d. Private insurance.

K. Social Services Fund:

The Social Service Fund provides assistance with various needs of families related to

transportation and lodging expenses in order to attend clinic appointments; emergency expenses such as utility assistance, rent, and clothing; and other expenses related to essential basic needs.

1. Funds obtained from sources other than the state, i.e., community social service agencies, insurance, donations, etc., should be utilized first in covering authorized social service expenditures. Social Service funds cannot be used to replace expenditures that are the responsibility of the health plan or insurer.
2. It is recommended that this fund be administered through the social services area of the CRS Clinics.
3. Each Social Service Fund expenditure must be documented on the CRSA supplied form as an expenditure on an enrolled child. Expenditures reported as spent on various items or for general use will not be accepted.
4. To receive reimbursement, expenditures made by CRS Contractors must be documented on forms provided by CRSA. Contractors should keep original receipts on file should CRSA request to review substantiating information. Copies of the required documentation and an original Contractor's Expenditure Report (CER) must be mailed to CRSA monthly or quarterly.

L. Social Work Services

Social work services include: information and referral, support and counseling, screening and assessment, and documentation and coordination of services.

1. CRS Contractors shall provide social work services for all CRS members and their families during the member's hospitalization, including coordination of the member's hospital discharge plan.
2. CRS Contractors shall provide social work services in the outpatient clinic for CRS members and families.
3. CRS Contractors may provide at least one social worker to attend specified multi-specialty, interdisciplinary clinics.
4. CRS Contractors shall perform psychosocial evaluations of the member and member's family as per R9-7-418.
5. Social workers must:
    a. Have a Masters Degree in Social Work (MSW) or a Bachelors Degree (BSW) in Social Work from a college or university accredited by the Council on Social Work Education.
    b. Be licensed as a social worker by the Arizona Board of Behavioral Health Examiners, or be eligible with license pending.
    c. Demonstrate proficiency in performing psychosocial evaluations or under the direction of a licensed social worker who is proficient.
    d. Demonstrate knowledge of the stages of childhood growth and development.

M. State Parent Action Council (SPAC)

1. The CRS Statewide Parent Action Council is established consisting of the following members:
    a. Two parents are appointed by each Parent Action Council. These members shall elect two members who are appointed to Co-Chair the Statewide Council.
    b. One representative from an advocacy group who is appointed by the Co-

Chairs of the Statewide Council.

c. One staff member from each CRS Contractor who is appointed by the CRS Contractor's Administrator.
d. One representative from CRSA who is appointed by the ADHS/OCSHCN/CRSA Office Chief.

2. Membership should have representation from all geographic regions of Arizona.
3. Members of the SPAC shall determine what officers the SPAC shall have, shall elect officers, and determine term limits for SPAC and SPAC officers.
4. Members appointed pursuant to the above sections b, c, and d, are non-voting members and are not counted for the purpose of determining the presence of a quorum.
5. The State Parent Action Council (SPAC) shall:
   a. Participate in any process that changes the laws, rules, policies, or procedures that influence the delivery of CRS services to children and families.
   b. Participate in any process regarding the planning and delivery of CRS services.
   c. Promote parent involvement in treatment planning, advocacy, and member care.
   d. Participate with CRSA in the ongoing definition of parent-member rights and responsibilities.
   e. Require one parent council member from CRS Contractor to participate in the Administrator's meetings between CRSA and the CRS Contractors.
   f. Require one parent council member from CRS Contractor to participate in the Medical Director/Administrator's meetings between CRSA and the CRS Contractors.
   g. Participate in the development and distribution of the Parent Involvement/PAC Fund.
   h. Meet bi-annually at a minimum or more often as determined by the membership. Members shall determine meeting places and times.
6. The Co-Chairs shall annually meet with the CRSA Medical Director to exchange ideas regarding the delivery of services to children and families.
7. Council members are not eligible to receive compensation, but are eligible for reimbursement of expenses.

N. Translation and Interpreter Services

CRS Contractors shall provide free translation and interpreter services to ensure that all CRS members and their families understand the member's diagnosis and course of recommended treatment in a culturally sensitive manner.

1. All vital materials shall be translated when CRS Contractor is aware that a language is spoken by 1,000 or 5% (whichever is less) of its members who also have Limited English Proficiency (LEP) in that language. Vital materials must include, at a minimum, notices of actions, member handbooks, and consent forms. Vital materials must include, at a minimum:
   a) Notices of actions
   b. New Member Orientation packet information and Member Handbook
   c. Consent forms
   d. Notices for denials

e. Reductions
f. Suspensions, or terminations of services
g. Consent forms
h. Communications requiring a response from the member
i. Informed consent
j. Request for hearing information

2. All written notices informing members of their right to interpretation and translation services in a language shall be translated when a CRS Contractor is aware that 1,000 or 5% (whichever is less) of its members speak that language and have LEP.
3. All materials shall be translated when a CRS Contractor is aware that a language is spoken by 3,000 or 10% (whichever is less) of its members who have LEP in that language.
4. Every effort shall be made to ensure that all material prepared for distribution is easily understood.
5. Written material shall be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited, have limited reading proficiency, or require sign language.
6. Individuals providing interpreter services to members/families must have an awareness and sensitivity to the culture and socio-economic background of the population in CRS and shall be fluent in the required language and understand medical terminology. Posted signage advising members of the availability, at no cost, of interpreter services is required.
7. Contractors shall document in the member's medical records the member's preferred language during the enrollment/intake process. When interpretative services are provided they must be documented in the member's medical chart.
8. CRS Contractors shall ensure staff/volunteers attend education sessions and maintain agenda and sign-in sheets of education on:
   a. Awareness and sensitivity to culture
   b. Socioeconomic conditions of the CRS population
9. CRS Contractors must ensure staff/volunteers providing translation/interpreter services are effective in assisting the family in participating, planning and decision making for medical care.
10. The Contractor shall make every effort to ensure that all information prepared for distribution to members is written in an easily understood language and format. CRS recipient information must be printed in a type, style and size that meets with ADA requirements.
11. The Contractor must notify members that material is available in alternative formats.
12. Auxiliary aids and services should be provided to individuals as needed. Auxiliary aids and services are as defined by the ADA and may include:
    a. Qualified interpreters, note-takers, written materials, telephone handset amplifiers, telephones compatible with hearing aids, telecommunications devices for deaf persons (TDD's), videotext displays, or other effective methods of making aurally delivered materials available to individuals with hearing impairments; and
    b. Qualified readers, taped texts, audio recordings, Brailled materials,

large print materials, or other effective methods of making visually delivered materials available to individuals with visual impairments.

13. Contractors shall document in the member's medical record the member's use of auxiliary aids and/or services during the enrollment/ intake process. When auxiliary aids and services are provided they must be documented in the member's medical chart.

M Member Material Requirements and Approval

1. All informational materials prepared for members shall be reviewed and approved by CRSA prior to publication and distribution to members. This also includes member material published on the contractor's website, mass e-mail messages to members, and voice recorded phone messages delivered en mass to member's telephones.
2. Customized letters for individual members do not need to be submitted to CRSA for approval.
3. Health related brochures developed by a nationally recognized organization (Attachment A) need not be submitted to CRSA for approval. The Contractor may submit names of other organizations to CRSA for approval. The Contractor will receive an updated copy of Attachment A as necessary.
4. The Contractor is not required to submit member material translated into a language other than English, however it is the contractor's responsibility to ensure the translation is accurate and culturally appropriate.
5. Contractors will be held accountable for the content of materials developed by the organizations listed in Attachment A. The Contractor should review the materials to ensure that:
   a. The services are covered under the CRS program
   b. The information is accurate
   c. The information is culturally sensitive
6. Brochures developed by outside entities must be supplemented with informational materials developed by the Contractor which are customized for the CRS population.
7. Information shall be submitted for approval via email (unless the material is not available in an electronic format).
8. Proposed materials shall be submitted to:
   Arizona Department of Health Services
   Children's Rehabilitation Services Administration
   Member Services Program Manager
   150 North 28th Avenue, Suite 330
   Phoenix, Arizona 85007
9. Proposed materials must be submitted 30 days before intended publication or distribution date. CRSA will notify the contractor in writing within fifteen (15) working days of receipt of the complete materials packet whether or not the materials have been approved, denied, or require modification.

Section 6.4 Telemedicine

A. Purpose

The purpose of telemedicine is to provide clinical and therapeutic services by means of telemedicine technology. This technology is used to deliver care and services directly to the member and to maximize the provider network. The technology can also be used to enhance communication, increase educational opportunities for members, members' families, CRS Contractor staff, and providers.

B. Services Provided

Services provided through telemedicine technology may include:

1. Regional outreach clinics,
2. Physician consultation,
3. Other professional consultation,
4. Family and professional education, and
5. Videoconference meetings or trainings.

Section 6.5 Transportation

A. Coordination

1. Transportation services are provided for a member who is receiving inpatient services from one CRS-contracted hospital to another CRS-contracted hospital.
2. Transportation services are provided for a member who is receiving services from a CRS provider to a CRS-contracted hospital if necessary to respond to an immediate threat to the life or health of the member.
3. Medically necessary, non-emergency transportation for an AHCCCS/KidsCare member must be coordinated with the member's AHCCCS Health Plan/Program Contractor.
4. For members with private insurance, the non-emergency transportation should be coordinated through the insurance carrier if the transportation is a covered benefit.

B. Exclusions

Transportation to clinic appointments is excluded.

Section 7.1 Scope of ADHS' Liability for Payments to Contractors

1. The Arizona Department of Health Services (ADHS) shall bear no liability for the provision of Children's Rehabilitative Services' (CRS) services or the completion of a plan of treatment to any member or eligible individual beyond the date of termination of such individual's eligibility and enrollment.
2. All payments to CRS Contractors shall be made pursuant to the terms and conditions of contracts executed between the CRS Contractor and ADHS, and in accordance with Arizona Administrative Rules.
3. CRS Contractors are responsible for any and all subcontracts executed with other parties for the provision of either administrative or management services for the CRS Program, medical services, covered services, or for any other purpose.

Section 7.2 Encounters Submissions and Claims Processing

A. Introduction

After rendering a covered service, billing information is submitted by the Children's Rehabilitative Services (CRS) program providers as a "claim" or as an "encounter". Some providers are reimbursed on a fee-for-service basis (these providers submit "claims") and other providers are paid on a capitated basis or contract under a block purchase arrangement (these providers submit "encounters"). The CRS Contractor submits encounters to the Arizona Department of Health Services (ADHS).

B. Encounters Submissions

1. The CRS Contractor must submit all encounters including resubmissions or corrections to the Arizona Department of Health Services (ADHS) within two hundred ten (210) days from the end date of service.
2. The CRS Contractors may be assessed sanctions for non-compliance with encounter submission requirements.
3. The Arizona Health Care Cost Containment System Administration (AHCCCSA) conducts data validation studies of Title XIX and Title XXI encounter submissions. A data validation study examines a sample of medical records to ensure that the encountered service has actually been provided. The CRS Contractors will also perform data validation studies.
4. A Trading Partner Agreement for Electronic Data Interchange (EDI) transactions must be in place between a CRS Contractor and provider before a provider can submit electronic claim/encounter data to a CRS Contractor.
5. General requirement applicable to CRS Contractors' providers when submitting encounters
    a. All encounters or copies of paper encounters:
        i. Must be legible and submitted on the correct form.
        ii. May be returned to the CRS Contractor without processing if they are illegible, incomplete, or not submitted on the correct form.
    b. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, regulations specify the format for the submission of all electronic claims and encounters submitted to the CRS Contractor.
        i. HIPAA Format 837P is used to bill or encounter non-facility services, including professional services, transportation, and independent laboratories.
        ii. HIPAA Format 837I is used to bill or encounter hospital inpatient, outpatient, emergency room, hospital-based clinic, and residential treatment center services
        iii. HIPAA Format NCPDP is used by pharmacists to bill or encounter pharmacy services using NDC codes.
    c. Submitted encounters for services delivered to eligible persons will result in one of the following dispositions:
        i. Rejected;
        ii. Pended; or

iii. Adjudicated.

d. Encounters are typically rejected because of a discrepancy between submitted form field(s) and the CRS Contractors' ADHSô or the Arizona Health Care Cost Containment System (AHCCCS) edit tables. A rejected encounter may be resubmitted as long as the encounter is submitted within the CRS Contractorsô established timeframe.

e. Encounters may pend at AHCCCS. CRS Contractors must resolve all pended encounters within one hundred twenty (120) days of the original processing date. CRS Contractors must not delete pended encounters as a means to avoid sanctions for failure to correct encounters within the specified number of days.

f. Adjudicated encounters have passed the timeliness, accuracy and completeness standards and have been successfully processed by ADHS (and AHCCCS for Title XIX/XXI eligible persons).

g. Submitted encounters for services delivered to Non-Title XIX/XXI enrolled persons must be submitted in the same manner and timeframes as described in this subsection. These encounters are not submitted to AHCCCS, but must be sent to CIS within two hundred ten (210) days from the end date of service.

h. Encounters for services delivered to Non-Title XIX/XXI enrolled persons will result in one of the following dispositions: Rejected or accepted.

i. Rejected encounters for services delivered to Non-Title XIX/XXI enrolled persons will be returned to the CRS Contractor with an explanation of the disallowance. A CRS Contractor may resubmit the encounter within two hundred ten (210) days from the end date of service.

6. Requirements applicable to the CRS Contractor when submitting encounters

a. All encounters must be submitted to ADHS within two hundred ten (210) day from the end date of service. Encounters received beyond the timeframe may be subject to timeliness sanctions.

b. Dates of service must not span a contract year. Contract year begin on October 1 and end on September 30. If a service spans a contract year, the claim must be split and submitted in two different date segments, thus, the dates of service do not span a contract year.

C. Claims Processing

1. The Childrenôs Rehabilitative Services (CRS) Contractors shall develop and maintain claims payment systems capable of processing, cost avoiding, and paying claims. For claims submitted for State-Only payments, claims submission deadlines shall be calculated from the date of service/date of discharge. For the Arizona Health Care Cost Containment System (AHCCCS) covered claims, the submission deadline shall begin with the date of service/discharge or, in the case of AHCCCS retro-eligibility, the date of the eligibility posting, whichever is later. A CRS Contractorôs claims payment system, as well as the prior

authorization and concurrent review process, must minimize the likelihood of having to recoup previously paid claims. Any individual recoupment in excess of $50,000 per provider within a contract year must be approved in advance by the Children's Rehabilitative Services Administration (CRSA). A detailed notification shall be sent to CRSA that describes:

a. How the need for recoupment was identified;
b. The systemic causes resulting in the need for a recoupment;
c. The process that will be utilized to recover the funds;
d. Methods to notify the affected provider(s) prior to recoupment;
e. The anticipated timeline for the project;
f. The corrective actions that will be implemented to avoid future occurrences;
g. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of providers impacted; and
h. Other recoupment action specific to this provider within the contract year.

CRSA must be notified of any cumulative recoupment greater than $50,000 per provider per contract year. A detailed notification shall be sent to CRSA that describes:

a. How the need for recoupment was identified;
b. The process that will be utilized to recover the funds;
d. Methods to notify the affected provider(s) prior to recoupment; and
e. Cumulative recoupment amount, total number of claims and range of dates for the claims being recouped.

A CRS Contractor shall not recoup monies from a provider later than twelve (12) months after the date of original payment on a clean claim, without prior approval from CRSA, unless the recoupment is a result of fraud, data validation, or audits conducted by CRSA or the Arizona Health Care Cost Containment System Administration (AHCCCSA), Office of Program Integrity. A detailed notification shall be sent to CRSA that describes:

a. How the need for recoupment was identified;
b. The systemic causes resulting in the need for a recoupment;
c. The process that will be utilized to recover the funds;
d. Methods to notify the affected provider(s) prior to recoupment;
e. The anticipated timeline for the project;
f. The corrective actions that will be implemented to avoid future occurrences; and
g. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of providers impacted.

2. CRS providers are reimbursed for covered services by CRS Contractors. CRS Contractors are responsible for the processing and adjudication of claims presented by CRS providers according to the terms of their contracts with those providers. CRS Contractors shall ensure that 90% of all clean claims are paid within thirty (30) days of receipt of the clean claim and 99% are paid within sixty (60) days of receipt of the clean

claim. The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at the CRS Contractorôs specified claim mailing address. The paid date of the claim is the date on the check or other form of payment. (See 42 C.F.R. § 447.45(d))

3. CRS Contractors submit claims and encounter information to Arizona Department of Health Services (ADHS) for program and financial management purposes. The complete, accurate, and timely reporting of encounter data is crucial to the success of the CRS program. CRSA uses encounter data to pay reinsurance benefits, set capitation rates, and to determine compliance with performance standards. CRS Contractors shall submit encounter data to CRSA for all services for which the CRS Contractor incurred a financial liability. Paid claims should be reconciled to the encounters to ensure that all paid claims have been encountered to CRSA.
4. Remittance advices accompanying CRS Contractorôs payments to providers must contain, at a minimum, adequate descriptions of all denial and adjustments, the reasons for such denials and adjustments, the amount billed, the amount paid, and their right to file a claim dispute. (See Section 7.5, Claim Dispute Process)
5. Fast payment discounts and slow payment penalties shall be applied as of 07/01/06 as follows:
   a. For hospital clean claims paid within thirty (30) days of the date the clean claim was received, the CRS Contractor shall pay 99% of the rate.
   b. If the hospital's clean claim is paid after thirty (30) days but within sixty (60) days of the date the clean claim was received, the CRS Contractor shall pay 100% of the rate.
   c. If the hospital's clean claim is paid any time after sixty (60) days of the date the clean claim was received, the CRS Contractor shall pay 100% of the rate plus a fee of 1% per month for each month or portion of a month following the sixtieth day of receipt of the clean claim until the date of payment. When a fee is paid, the subcontractor must report the fee separately from the health plan paid amount on the encounter. The fee should be reported in the 837 CAS adjustment loop using reason code ñ85.ò
6. The CRS Contractorsôclaims receipt guidelines shall be as follows:
   a. Initial receipt of claims must be within six (6) months of the claim submission dates described in Section 7.2(1), unless a shorter time period is specified in contract.
   b. Claims received beyond the six (6) month time frames defined above shall be denied.
   c. For claims received within the six (6) month time frame, the provider has up to twelve (12) months from the date of service to resubmit a clean claim.
   d. Claim receipt requirements pertain to both contracted and non-contracted providers.
7. CRS Contractors are required to accept Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, (HIPAA) compliant

electronic claims transactions from any provider interested and capable of electronic submission; and must be able to make claims payments via electronic funds transfer. CRS Contractors shall monitor the ratio of electronic claims to hard copy claims received into the claims processing system, the ñtime to processò electronic claims versus hard copy claims, the effect that the volume of electronic claims processing has on claims processing metrics, and the effect that electronic claims processing has on the CRS Contractors quality standards (goals). In addition, CRS Contractors shall implement and meet the following milestones in order to make claims processing and payment more efficient and timely:

a. CRS Contractors must be able to make claims payments via electronic Funds Transfer by June 30, 2006; and
b. CRS Contractors are required to receive and pay claims electronically by June 30, 2006.

8. The CRS Contractors shall develop and maintain an electronic health information system that collects, integrates, analyzes, and reports data. The system shall provide information on areas including, but not limited to, service utilization, claim disputes, and appeals. (See 42 C.F.R. § 438.242(a)) The CRS Contractors will ensure that changing or making major upgrades to the information systems effecting claims processing, or any other major business component, will be accompanied by a plan which includes a timeline, milestones, and adequate testing before implementation. At least seven (7) months before the anticipated implementation date, the CRS Contractors shall provide the system change plan to CRSA for review.
9. Claims submitted to the CRS Contractors shall include:
   a. Completion of all fields on the appropriate claim forms;
   b. The provider services requisition (PSR) authorization number;
   c. Valid service-specific diagnostic and procedural codes;
   d. Usual customary charges that shall be broken out for each valid code submitted;
   e. Accurate modifiers, where appropriate;
   f. Operative report for surgical procedures;
   g. Physiciansô orders and progress notes for durable medical equipment (DME);
   h. All supportive documentation (reports, progress notes, orders) for services other than surgery (e.g., intensive care unit (ICU) visits, consultations, admissions); and
   i. All explanations of benefits (EOB) that relate to the claim (CRS is the payor of last resort).
10. Claims submitted without the above information or with inaccurate codes will automatically be returned to the provider for proper resubmission or other disposition.

Section 7.3 Collecting Payments for CRS Services

This section pertains to the requirements for the Children's Rehabilitative Services (CRS) Contractors obtaining payment for services provided to CRS members. This includes coordination of benefits and member responsibilities. The Children's Rehabilitative Services Administration (CRSA) requires CRS Contractors to be responsible for coordination of benefits for services provided. The two methods used in the coordination of benefits are cost avoidance and post-payment recovery.

A. Coordination of Benefits (Applies to members under the 200% Federal Poverty Line)

1. Because the State of Arizona is the payor of last resort for the State-Only CRS population while Arizona Health Care Cost Containment System (AHCCCS) is, in most instances, the payor of last resort for the AHCCCS CRS population, the CRS program, as funded by the State and AHCCCS, shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. CRS Contractors shall coordinate benefits in accordance with 42 C.F.R. § 433.135 et seq., A.R.S. § 36-2903, and A.A.C. R9-22-1001 et seq. so that costs for services otherwise payable by CRS Contractors are cost avoided or recovered from a liable first- or third-party payor. CRS Contract Providers are to make all reasonable efforts to collect from insurance companies and other third-party payors.
2. If a member (other than a State-Only 100% pay member) has insurance which covers the CRS services provided, the member (other than a State-Only 100% pay member) shall not be billed the residual, regardless of the member's payment responsibility.
3. A CRS Contractor is responsible for collecting payments from insurance companies, managed care organizations, and all other third-party payors in accordance with member and family insurance policies, the CRS Contractor's contractual arrangements with the payors, and all applicable Arizona statutes.
4. AHCCCS requires that all AHCCCS members with a CRS eligible medical condition, without private insurance, enroll with CRS. For those members with a CRS eligible condition, with private insurance, enrollment with CRS shall be optional. AHCCCS members with private insurance choosing not to enroll with CRS may seek the payment of applicable copays and deductibles from the AHCCCS health plan/program contractor with whom they are enrolled. When the private insurance is exhausted with respect to CRS covered conditions, the AHCCCS health plan/program contractor is required to refer the member to CRSA for determination for CRS services. For those members with private insurance who are enrolled in the CRS program, the CRS Contractors are responsible for applicable copays and deductibles related to the CRS condition. CRS Contractors are not responsible for paying coinsurance and deductibles that are in excess of what the CRS Contractor would have paid for the entire service per a written contract with the provider performing the service, or the AHCCCS fee-for-service (FFS) payment equivalent. If the CRS Contractor refers

the member for services to a third-party insurer (other than Medicare), and the insurer requires payment in advance of all co-payments, coinsurance, and deductibles, the CRS Contractor must make such payments in advance.

5. When services are provided by the CRS program, which are outside the covered benefits provided by the insurer, the insurer is not required to pay for those services. If the member is a State-Only 100% pay member, the family or member is responsible to pay for the services not covered by third-party insurance according to what the CRS Contractor would have paid for the entire service per a written contract with the provider performing the service or the AHCCCS FFS payment equivalent.
6. If the CRS Contractor does not know whether a particular service is covered by the third party, and the service is medically necessary, the CRS Contractor shall contact the third party and determine whether such service is covered rather than requiring the member to do so. In the event that the third party does not cover the service, the CRS Contractor shall arrange for the timely provision of the service.
7. The requirement to cost-avoid applies to all CRS covered services. In emergencies, the CRS Contractor shall provide the necessary services and then coordinate payment with the third-party payor. Further, if a service is medically necessary, the CRS Contractor shall ensure that its cost avoidance efforts do not prevent a member from receiving such service and that the member (other than a State-Only 100% pay member) shall not be required to pay any coinsurance or deductibles for use of the other insurer's providers.
8. The amount of the payment due from the insurer or other third-party payor is as follows:
    a. Third-party payors, excluded as health care services organizations as described under A.A.C. Title 20, Chapter 4, Article 9 shall be billed the provider's usual and customary charges with payments subject to the payor's requirements for deductible and coinsurance.
    b. If a third-party insurer (other than Medicare) requires the CRS member to pay any co-payment, co-insurance, or deductible, the CRS Contractor is responsible for making these payments, even if the services are provided outside of the CRSA network.
    c. CRS Contractors are generally responsible for payment of Medicare coinsurance and/or deductibles for covered services provided to dual eligible members. However, there are different cost sharing responsibilities that apply to dual eligible members based on a variety of factors. CRS Contractors are responsible for adhering to the cost sharing responsibilities presented in the AHCCCS Contractors Operations Manual (ACOM), Chapter 200, Claims, Medicare Cost Sharing for Members in Medicare FFS/HMO (See http://www.ahcccs.state.az.us/Publications/GuidesManuals/ACOM/ACOM.pdf). CRS Contractor shall have no cost-sharing obligation if the Medicare payment exceeds what the CRS Contractor would have paid for the same service of a non-

Medicare member.

9. CRS Contractors shall not bill AHCCCS Health Plans for CRS services.
10. Post-payment recovery is necessary in cases where the CRS Contractor was unaware of third party coverage at the time services were rendered or paid for, or was unable to cost-avoid. The CRS Contractor may retain up to 100% of its third party collections if all of the following conditions exist:
    a. Total collections received do not exceed the total amount of CRSA financial liability for the recipient;
    b. There are no payments made by AHCCCS related to FFS, reinsurance or administrative costs (i.e., lien filing, etc.); and,
    c. State or Federal law does not prohibit such recovery.
11. The CRS Contractor shall identify all potentially liable third parties and pursue reimbursement from them except the CRS Contractor shall not pursue reimbursement for Title XIX and Title XXI enrolled CRS members in the following circumstances unless the case has been referred to CRSA by AHCCCS or AHCCCS's authorized representative:
    a. Uninsured/ underinsured motorist insurance;
    b. First- and third-party liability insurance;
    c. Tortfeasors, including casualty
    d. Restitution recovery;
    e. Worker's compensation;
    f. Estate recovery; and,
    g. Special treatment trust recovery.
12. The CRS Contractor shall report to CRSA all cases for which:
    a. The CRS Contractor identifies circumstances in 12(a)-(g)- through above.
    b. The CRS Contractor shall cooperate with AHCCCS's authorized representative in all collection efforts.
14. The CRS Contractor may be required to report case level detail of third-party collections and cost avoidance including number of referrals on total plan cases. The CRS Contractor shall communicate any known change in or addition to health insurance information, including Medicare, to CRSA, not later than ten (10) days from the date of discovery using AHCCCS approved correspondence or AHCCCS approved third-party correspondence.

B. Member Responsibility

1. A member shall participate in the cost of care by paying for services in the amounts described in Chapter 4.5, Member Payment Responsibility Standards.
2. The CRS Contractor shall be responsible for collecting co-payments specified in Chapter 4.5, Member Payment Responsibility Standards. Any required co-payments collected shall belong to the CRS Contractor or providers.
3. Except for permitted co-payments, the CRS Contractor or providers shall not bill or attempt to collect any fee from, or for, an AHCCCS recipient for the provision of covered services.
4. The CRS Contractor shall ensure that a member with a payment

responsibility category of less than or equal to 200% Federal Poverty Level (FPL) is not denied services because of that member's inability to pay a co-payment or deductible.

5. The CRS Contractor is responsible for collecting applicable payment amounts from members with a payment category of greater than 200% FPL. The CRS Contractor shall not deny services because of a member's inability to pay a co-payment or deductible for State-Only 100% pay members who have third party insurance.
6. The CRS Contractors may recover from a member what the CRS Contractor has paid a provider up to the payments made by a third-party payor to the member. The amount recovered from the member should not exceed the amount that the CRS Contract paid to the provider. The CRS Contractor would not recover from a member if the third-party payor assigned payment to the CRS Contractor.
7. Claims for CRS services shall not exceed the CRS Contractor's or the subcontractor's usual and customary rates.
8. A CRS Contractor may bill a member or family for medical expenses incurred during a period of time when the member or family willfully withholds material information from the CRS Contractor or provides false information pertaining to CRS, AHCCCS, KidsCare, or private insurance eligibility or enrollment status that results in denial of payment due to failure to disclose such information or the provision of false information.
9. The CRS Contractors or their designees must adhere to the prior authorization requirements of all health service organizations. Neither families nor the CRS Program are responsible for the payment of services where payment was denied by a third-party payor because the CRS Contractor failed to comply with preauthorization or other utilization management procedures.

Section 7.4 Denied Claims

1. The Children's Rehabilitative Services (CRS) Contractors will provide written notifications to providers for all claims that are denied in part or for which a partial payment is made.
2. Notifications must contain:
   A. Date of denial;
   B. Services being denied or not included in payment;
   C. Reason for the denial or reduction in payment; and
   D. Providers' right to file a claim dispute and how to file a claim.

Section 7.5 Claim Dispute Process

A. Time Frame for Filing Claim Dispute

Claim disputes must be filed in writing with the Children's Rehabilitative Services (CRS) Contractor no later than twelve (12) months from the date of service, within twelve (12) months of the date that Arizona Health Care Cost Containment System (AHCCCS) eligibility is posted, or within sixty (60) days after the payment, denial, or recoupment of a timely claim submission, whichever is later. (See A.R.S. § 36-2903.01(B)(4))

B. Claim Dispute Policy and Process

1. The CRS Contractors shall have in place a written claim dispute policy for providers regarding adverse actions taken by the CRS Contractor. The policy shall be in accordance with applicable Federal and State laws, regulations, and policies.
2. A Provider Claim Dispute policy shall be provided to all subcontractors at the time of contract. For providers without a contract, the claim dispute policy may be mailed with remittance advice, provided the remittance is sent no later than forty-five (45) days of receipt of a claim.
3. All documentation received by the CRS Contractor during the claim dispute process shall be dated upon receipt. Specific individuals shall be appointed with authority to require corrective action and with requisite experience to administer the claim dispute process. Each claim dispute shall be thoroughly investigated using the applicable statutory, regulatory, contractual, and policy provisions, ensuring that facts are obtained from all parties. All claim disputes with the appropriate documentation shall be filed separately in a secure designated area and shall be retained in a reproducible format for five (5) years following the CRS Contractor's decision, the Administration's decision, judicial appeal, or close of the claim dispute, whichever is later, unless otherwise provided by law. Each claim dispute file must contain documentation of the written claim dispute, acknowledgment letter, all documentation received during the claim dispute process, request for extension of decision (if applicable), other information relevant to the notice of decision of the claim dispute, notice of decision letter, documentation of reprocessing and paying the claim within fifteen (15) business days of the date of the decision (if the claim dispute is overturned), provider's written hearing request (if applicable), and hearing request cover letter to AHCCCS (if applicable).
4. The CRS Contractors are required to track, trend, and analyze claim disputes for purposes of detecting fraud and/or abuse and system improvement. Any suspected fraud and abuse detected must be reported consistent with the requirements in Chapter 12.2, Quality of Care Issues, of this manual.

C. Filing a Claim Dispute

1. For a claim for CRS services rendered to a member, the provider shall file a written claim dispute with the CRS Contractor under the timelines in this policy. A claim dispute shall specify in detail the factual and legal basis for the claim dispute and the relief requested.

2. Within five (5) working days of receipt, the provider shall be informed by letter that the claim dispute has been received.
3. The CRS Contractor shall mail a written Notice of Decision of the claim dispute to the provider no later than thirty (30) calendar days after the provider files the claim dispute with the CRS Contractor, unless the provider and the CRS Contractor agree to a longer period. Documentation of an extension of time must be maintained in the claim dispute file.
4. The CRS Contractor's written Notice of Decision shall include and describe in detail the following:
   a. The nature of the claim dispute
   b. The issues involved
   c. The reasons supporting the CRS Contractor's decision, including references to applicable statute, rule, contractual provisions, policy, and procedure
   d. The provider's right to request a hearing by filing a written request for hearing to the CRS Contractor no later than thirty (30) days after the date the provider receives the CRS Contractor's decision.
   e. If the claim dispute is overturned, it is required that the CRS Contractor shall reprocess and pay the claim in a manner consistent with the decision within fifteen (15) business days of the date of the decision. The CRS Contractor shall have a process for internal communication and coordination when an appeal or claim dispute decision is reversed.
5. If the provider files a written request for hearing, the CRS Contractor must ensure that all supporting documentation is received by the AHCCCS, Office of Administrative Legal Services, no later than five (5) working days from the date the CRS Contractor receives the provider's written hearing request from AHCCCS, Office of Administrative Legal Services. The file above sent by CRS Contractor must contain a cover letter that includes:
   a. Provider's name
   b. Provider's AHCCCS ID number
   c. Provider's address
   d. Provider's phone number (if applicable)
   e. The date of receipt of claim dispute
   f. A summary of the CRS Contractor's actions undertaken to resolve the claim dispute and basis of the determination
6. The following material shall be included in the file noted in C(5) of this policy sent by CRS Contractor:
   a. Written request for hearing filed by the provider
   b. Copies of the entire file that includes pertinent records; and CRS Contractor's decision
   c. Other information relevant to the Notice of Decision of the claim dispute
7. If CRS Contractor's decision regarding a claim dispute is reversed through the appeal process, the CRS Contractors shall reprocess and pay the claim in a manner consistent with the decision within fifteen (15) business days of the date of the decision.

Section 8.1 General Standards

A. Policies

1. Children's Rehabilitative Services (CRS) Contractors shall maintain internal policies and procedures for grievance and appeal resolution processes that meet Children's Rehabilitative Services Administration (CRSA) standards as described in this chapter.
2. Members and/or their representatives shall be informed about grievance and appeal procedures at the time of eligibility contact, upon request, or when changes occur in the policy.
3. Providers shall be given a copy of the member grievance and appeal policies at the time of contract, upon request, or when changes occur in the policies.
4. The CRS Contractors shall ensure that punitive action is not taken against a provider who supports a member's grievance, or appeal, or who requests an expedited resolution to an appeal.
5. The CRS Contractors shall ensure that individuals who make decisions on grievances and appeals are individuals:
    a. Who were not involved in any previous level of review or decision-making, and
    b. For medical necessity decisions or cases involving clinical issues, are health professionals who have the appropriate clinical expertise in treating the member's condition or disease.

B. Records

1. All records obtained for the CRS Program grievance and appeal processes are filed separately in a secure, designated area, and are retained in reproducible format for a minimum of six (6) years.
2. The files must contain documentation of all acknowledgment, investigation, and resolution activities related to each grievance and appeal.

C. Date of Filing

1. CRSA and the CRS Contractors will consider the grievance, appeal, or State Fair Hearing request as filed on the date it is received by CRSA or the CRS Contractor.
2. All written grievances and appeals and any incoming correspondence related to grievances and appeals must be date stamped upon arrival.

D. Reasonable Assistance

A CRS Contractor shall provide reasonable assistance to members in completing forms and taking other procedural steps. Reasonable assistance includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD (teletypewriter/telecommunications device for the deaf, and text telephone) and interpreter capability.

E. Computation of Time

1. Computation of time in calendar days begins the day after the act, event, or decision and includes all calendar days and the final day of the period. If the final

day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday.

2. Computation of time in business days begins the day after the act, event, or decision and includes all business days.

Section 8.2 Grievance Process

A. Who May File

1. A member or a member's parent or guardian may file a grievance.
2. A provider who is acting as the member's authorized representative may file a grievance on behalf of a member with the written consent from the member.

B. Time Frame for Filing a Grievance with CRSA or CRS Contractor

A grievance, either orally or in writing, may be filed with Children's Rehabilitative Services Administration (CRSA) or the Children's Rehabilitative Services (CRS) Contractor at any time. As CRSA desires to have issues resolved as expeditiously as possible, the member or his/her representative should be encouraged to file directly with the CRS Contractor.

C. Time Frame for Standard Disposition of a Grievance

1. The CRS Contractor shall acknowledge receipt of each grievance orally or in writing no later than five (5) business days after receipt. Potential quality of care concerns must have written acknowledgement (Attachment 1, Non-Quality Of Care Grievance Acknowledgement Letter).
2. The CRS Contractor shall complete disposition and provide oral or written notice to the member of the grievance resolution as expeditiously as possible. Potential quality of care resolutions require a written notice to the grievant. Most grievances should be resolved within ten (10) business days but in no case longer than ninety (90) calendar days.

D. Grievance Resolution

1. CRS Contractors shall have written policies and procedures for reviewing, evaluating, and resolving grievances, regardless of who within the organization receives the grievances, that include:
    a. Documenting each grievance raised, when and from whom it was received;
    b. That is the responsibility of the CRS Contractor's Quality Management Coordinator to make a prompt determination of whether the grievance is a non-quality of care concern or a quality of care concern and assigning a severity level (Zero equals non-quality of care and one and above equal quality of care issues);
    c. Determining priority status;
    d. That all Quality of Care Issues are resolved in compliance with Contractors Policy and Procedure Manual Section 12.2;
    e. Assisting the member or provider as needed in completing forms or taking other necessary steps to obtain resolution of the issue;
    f. Ensuring confidentiality of all member information; and
    g. Documenting all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each grievance on both an individual and system level including, but not limited to:

i. Interventions, including the provision of immediate medical needs as approved by the CRS Medical Director;
ii. Monitoring of the outcome of the interventions;
iii. Incorporation of the interventions, if successful, into the CRS Contractor system of care to reduce/eliminate the likelihood of the issue reoccurring;
iv. Follow-up with the member that includes, but is not limited to:
1) Assistance as needed to ensure that the immediate health care needs are met; and
2) Closure/resolution letter on the CRS Contractor's letterhead that provides sufficient detail to ensure all covered, medically necessary care needs are met; contact name/title and telephone number to call for assistance or to express any unresolved concerns; the name, title, and credentials of the person signing the letter; and, if applicable, the Member's Arizona Health Care Cost Containment System (AHCCCS) ID number.
a) For non-quality of care resolution letters use Attachment 2, Non-Quality Of Care Grievance Resolution Letter, as a template;
b) For quality of care resolution letters use Attachment 3, Quality of Care Resolution Letter, as a template.

h. Documenting closure of the review.

2. Additional actions by the CRS Contractors may be necessary, based on individual case circumstances, before a case is closed. These actions may include:
a. if the case was received from CRSA or if CRSA desires to review the investigative steps and proposed resolution, submission of the entire file with all documentation to CRSA;
b. referring/reporting the issue to appropriate regulatory agency, AHCCCS, Child or Adult Protective Services, and CRSA for further research/review or action;
c. notifying the appropriate regulatory/licensing board or agency and CRSA when a health care professional's, organizational provider's, or other provider's affiliation with its network is suspended or terminated because of quality of care issues;
d. additional interventions/approaches if the original intervention is not successful or additional actions are required to fix the system;
e. in-services documented through attendance sign-in sheets and notes;
f. new policies and procedures; and/or
g. referral to the CRSA Peer Review Committee.

Attachment 1

Non-Quality of Care Grievance Acknowledgement Letter

(On Contractor Letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.

XXX-XXX-XXXX or (800) XXX-XXXX

Date

(*Name of person filing the grievance)*
Address
City, State, Zip

RE: *(CRS Member # & AHCCCS* # if *applicable)*

Dear *(Name)*:

It is important to us that you are happy with the care and service that you get from us. We have received your complaint and we will be looking into it. As soon as possible, we will send you a response.

Thank you for letting us know about your problem. If you have any questions, you can call XXXXX, at (602) XXX-XXXX.

Sincerely,

(*Name and credentials)*
(*Title*)

Cc:
XXX

Attachment 2

Non-Quality of Care Grievance Resolution Letter

(On Contractor Letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.

XXX-XXX-XXXX or (800) XXX-XXXX

DATE

(*Name of person filing the grievance)*
Address
City, State, Zip

RE: *(CRS Member # & AHCCCS* # if *applicable)*

Dear *(Name)*:

We have looked at your complaint. We have found (or decided) . We have made this decision based on *(Please include the legal citations or authorities supporting the determination, if applicable.)*

Thank you for letting us know about your complaint. If you have questions, you may call me at (XXX) XXX-XXXX.

Sincerely,

Name and credentials
Title

Attachment 3

Quality of Care Resolution Letter

(On Contractor Letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.

XXX-XXX-XXXX or (800) XXX-XXXX

Date

(Name of person filing the grievance
Address
City, State, Zip)

RE: *(CRS Member # & AHCCCS* # if *applicable)*

Dear *(Name)*:

(Phoenix, Tucson, Flagstaff, Yuma) Children's Rehabilitation Services has completed its review related to XXXXXXXXXXXXXXXXXX.

Provide explanation in lay person's terms

This information will be kept confidential under 42 C.F.R. § 434.34, A.R.S. § 8-546.11(C)(11), A.R.S. § 36-2401, et seq., A.R.S. § 36-445, and A.R.S. § 41-1959C(5).

Thank you for contacting CRS regarding this issue. The quality of health care of all of our members is important to us. You can contact XXXXXX, at (XXX) XXX-XXXX if you have any questions regarding this issue.

Sincerely,

Name and credentials
Title

Section 8.3 Appeal Process

A. Who May File

1. A member or a member's parent or guardian may file an appeal.
2. A provider, acting on behalf of the member, with the member's written consent, may file an appeal.

B. Requirements for Appeal Process

1. The Children's Rehabilitative Services (CRS) Contractor shall acknowledge receipt of each appeal in writing (See Attachment 1, Appeal Acknowledgement Letter) no later than five (5) business days after receipt of a standard appeal and within one (1) business day of receipt of an expedited appeal.
2. The CRS Contractor shall provide a reasonable opportunity for a member or his/her representative to present evidence and allegations of fact or law in person and/or in writing. The CRS Contractor shall inform the member of the limited time available for such presentation in the case of an expedited resolution.
3. The CRS Contractor shall provide the member and representative the opportunity, before and during the appeal process, to examine the member's case file, including medical records, documents, and records considered during the appeal process not protected from disclosure by law.
4. The CRS Contractor shall notify the Children's Rehabilitative Services Administration (CRSA) immediately if the appeal request makes mention of any quality of care issues of severity level two or above.
5. All letters sent out during the appeals process shall follow the language of the appropriate templates found at the back of this chapter; be sent on the CRS Contractor's letterhead; identify the name, title, and phone number of the person who is sending the response; and, if applicable, include the member's Arizona Health Care Cost Containment System (AHCCCS) ID number.

C. Time Frame for Filing an Appeal

A member or a provider acting as the designated representative and with the member's consent must appeal either orally or in writing to the CRS Contractor within sixty (60) days after the date of the Notice of Action.

D. Standard Resolution of an Appeal

1. For standard resolution of an appeal, the CRS Contractor shall resolve the appeal and mail the written Notice of Appeal Resolution (See Attachment 3, Notice of Appeal Resolution Letter) to the member within thirty (30) calendar days from the day the CRS Contractor receives the appeal.
2. If the member requests an extension of the thirty (30) day time frame in subsection (1), the CRS Contractor shall extend the time frame up to an additional fourteen (14) days.
3. If the CRS Contractor needs additional information and the extension is in the best interest of the member, the CRS Contractor shall extend the time frame in subsection (1) up to an additional fourteen (14) days. If the CRS Contractor extends the time frame, the CRS Contractor shall:

a. Give the member written notice (Notice of Extension of Resolution using sample letter (See Attachment 2, Request for Extension of Appeal Resolution Time Frame Letter) of the reason for the decision to extend the time frame, and
b. Issue and carry out the resolution as expeditiously as the member's health condition requires but no later than the date the extension expires.

E. Expedited Resolution of an Appeal

1. The CRS Contractor shall establish and maintain an expedited review process for appeals from a member/member's representative or the provider (in making the request on behalf of the member or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.
2. The CRS Contractor shall conduct an expedited appeal if:
   a. The CRS Contractor receives a request for an appeal from a member/member's authorized representative and the CRS Contractor determines that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function;
   b. The CRS Contractor receives a request for an expedited appeal from a member/member's authorized representative who believes that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function;
   c. The CRS Contractor receives a request for an expedited appeal directly from a provider, with the member's written consent, and the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.
3. For expedited resolution of an appeal, the CRS Regional Contractor shall resolve the appeal, make reasonable efforts to provide oral notice, and mail the written Notice of Appeal Resolution to the member within three (3) business days from the day the CRS Contractor receives the expedited appeal request.

F. Time Frame for an Expedited Appeal Resolution

1. If the CRS Contractor denies a request for an expedited resolution, it must transfer the appeal to the thirty (30) day time frame for a standard appeal. The CRS Contractor must make reasonable efforts to give the CRS member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice of the denial of an expedited resolution.
2. Expedited appeals must be resolved within three (3) business days of receipt of the request. If the member requests an extension of the three (3) business day time frame, the CRS Contractor shall extend the time frame up to an additional fourteen (14) days.
3. If the CRS Contractor needs additional information and the extension is in the best interest of the CRS member, the CRS Contractor shall extend the time frame up to an additional fourteen (14) days. If the time frame is extended, the CRS Contractor shall:

a. Give the member written notice (Notice of Extension of Resolution) of the reason for the decision to extend the time frame; and
b. Issue and carry out the determination as expeditiously as the CRS member's health condition requires and no later than the date the extension expires.

G. Notice of Appeal Resolution

The CRS Contractor shall use the Notice of Appeal Resolution letter (See Attachment 3).

H. Request for Review Process by ALTCS/Acute Care Contractors

1. Request for Review means a request by an AHCCCS Health Plan/Program Contractor's Medical Director asking the CRS Medical Director to review a new service denial or a reduction, suspension, or termination of a previously authorized service for a Title XIX or Title XXI member (See Section 11.2, Notice of Action, Notice of Service Authorization Extension, and Notice to ALTCS/Acute Care Provider and Health Plan (only to be applied to eligible and enrolled Title XIX/XXI members) for procedures related to sending out the denial notice).
2. When a denial is deemed a "non-covered CRS service," the AHCCCS health plan/program Ccontractor Medical Director may appeal the decision in writing with the CRS Medical Director no later than ten (10) business days of the date of decision by asking for a Request for Review.
3. The CRS Medical Director must respond within ten (10) business days from date of receipt of the Request for Review from the AHCCCS health plan/program contractor.
4. **A Notice must be sent by the CRS Contractor advising the ALTCS/Acute Care Medical Director of the review decision and of the right of the Arizona Long Term Care System (ALTCS)/Acute Care Contractor, in the event that the ALTCS/Acute Care Contractor disagrees with the decision, to file a request for hearing with AHCCCS Administration within thirty (30) days of receipt of decision by the CRS Contractor. (See letter #4 for the language to be included in the Notice).**
5. If the ALTCS/Acute Care Contractor provides the service that CRS has denied, and the AHCCCS Hearing Decision determines that the service should have been provided by CRS, CRS shall be financially responsible for the costs incurred by the ALTCS/Acute Care Contractor in providing the care.

Attachment 1

Appeal Acknowledgement Letter

(On Contractor Letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.

XXX-XXX-XXXX or (800) XXX-XXXX

Date

(*Name of person filing the appeal)*
Address
City, State, Zip

RE: *(CRS Member # & AHCCCS* # if *applicable)*

Dear *(Name)*:

We have received your appeal and will consider it. A written response will be sent to you within 30 days.

Thank you for contacting us about this issue. The quality of health care of all of our members is important to us. You can call XXXXXXXX, at (602) 000-0000 if you have any questions.

Sincerely,

Name and credentials Title

Cc:
XXXX

Attachment 2

Request for Extension of Appeal Resolution Time Frame Letter

(On Contractor Letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.

XXX-XXX-XXXX or (800) XXX-XXXX

Date

(*Name of person filing the appeal*
Address
City, State, Zip)

RE: *(CRS Member Name, Member # & AHCCCS* # if *applicable)*

Dear *(Name)*:

We would like to take up to 14 extra days to look into your appeal. *).* These extra days to make a decision benefit you by allowing us to have more complete information about the services you want given. We will make every effort to complete our review as soon as possible. We will take no longer than a total of 44 days from the day we received your appeal.

On behalf of (*Phoenix, Tucson, Flagstaff, Yuma)* CRS, thank you for your patience and understanding. You can contact XXXXXXXX, at (602) 000-0000 if you have any questions regarding this issue.

Sincerely,

XXXXXXXXXXX
Name and credentials
Title
Cc: XXXX

Attachment 3

Notice of Appeal Resolution Letter

(On Contractor Letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.

XXX-XXX-XXXX or (800) XXX-XXXX

DATE
(Name of person filing the grievance
Address
City, State, Zip)

RE: *(CRS Member # & AHCCCS* # if *applicable)*

Dear *(Name)*:

We received your letter of (*Date)*, asking that we look again at our decision to _____ . (*repeat decision in layperson terms*)

We have looked at the decision again. We have decided (*that the first decision was right/* ***or****/ to change our decision to* [*describe decision in lay person's language*]_____. We have made this decision based on *(Please include the legal citations or authorities supporting the determination.)*

If you do not agree with our decision you can tell us you want a State Fair Hearing. You must ask for the hearing in writing within 30 days from the day you receive this Notice of Appeal Resolution. If we do not hear from you by then, our decision will be final.

If you are now getting a service that is being cut back or stopped, you have the right to ask that this service be continued during the time it takes to receive a decision from the State Hearing. You must ask for the State Fair Hearing and services to continue within ten calendar days from date of this letter. If the decision does not support your request, you may have to pay for the services in question.

If you have questions, you may call XXXX at (XXX) XXX-XXXX.

Sincerely,

Name and credentials
Title

Attachment 4

(CRS Contractor Letterhead)

Notice of Decision by CRS on AHCCCS Health Plan/ Program Contractor Request for Review

Date

To: Health Plan Name

Address

Re: (*Member name, CRS Member # and AHCCCS ID#*)

Dear: (*Plan Medical Director*)

We received your Request for Review dated _____ asking us to review our decision

to _____.

After reviewing our original decision, we have decided (*that the first decision was right/* ***or****/ to change our decision to* _____.) We have made this decision based on *(Please include the legal citations or authorities supporting the determination.)*

If you do not agree with our decision you may file a request for a hearing with the AHCCCS Administration within 30 days of receipt of this letter.

If you have questions, please call us at *(XXX) XXX-XXXX.*

Sincerely,

_____
CRS Medical Director

Section 8.4 Applicant/Member Eligibility Hearing Process

A. Request for a State Fair Hearing

A member may request a State Fair Hearing of the Children's Rehabilitative Services (CRS) Contractor resolution to uphold its original adverse decision.

B. Filing Timeframes

1. The CRS Contractor will forward to the Arizona Health Care Cost Containment System (AHCCCS) (Title XIX and Title XXI members) requests for State Fair Hearings to AHCCCS Office of Legal Assistance (OLA) within five (5) business days of receipt.
   Office of Legal Assistance
   AHCCCS Administration
   701 East Jefferson
   Phoenix, AZ 85034
2. The CRS Contractor will forward Arizona Department of Health Services (ADHS) (non-AHCCCS member) requests for State Fair Hearings to the Children's Rehabilitative Services Administration (CRSA) within five (5) business days of receipt.
   Arizona Department of Health Services
   Office of the Director
   Counsel and Legal Support Unit
   150 North 18th Avenue, Suite 500
   Phoenix, Arizona 85007-3247

C. Request for an Expedited State Fair Hearing

A member may request an expedited State Fair Hearing on the CRS Contractor resolution of an expedited appeal. The request shall be in writing, submitted to and received by the CRS Contractor no later than thirty (30) calendar days after receipt of the CRS Contractor Notice of Appeal Resolution.

D. Time Frame for Resolution of an Expedited State Fair Hearing

Within three (3) business days of the receipt of a response from an expedited State Fair Hearing for AHCCCS (Title XIX and Title XXI members) or ADHS (non-AHCCCS members), AHCCCS or ADHS shall mail to the member the response from the State Fair Hearing. AHCCCS or ADHS shall make reasonable efforts to provide oral notice of the decision.

E. Denial of a Request for a State Fair Hearing

AHCCCS (Title XIX and Title XXI members) or ADHS (non-AHCCCS members) shall deny a request for a State Fair Hearing under A.R.S. § 41-1092, et seq., upon written determination that:

1. The request for hearing is untimely;
2. The request for hearing is not for an action permitted under this policy;
3. The request for hearing is moot, based on the factual circumstances of each case, as determined by AHCCCS or ADHS, based on factual circumstances of each case; or

4. The sole issue presented is a Federal or State law requiring an automatic change adversely affecting some or all enrollees.

F. Withdrawal of a Request for a State Fair Hearing

1. AHCCCS (Title XIX and Title XXI members) or ADHS (non-AHCCCS members) shall accept a written request for withdrawal from the member if the Notice of Hearing has not been mailed.
2. If AHCCCS (Title XIX and Title XXI members) or ADHS (non-AHCCCS members) has mailed a Notice of Hearing, AHCCCS (Title XIX and Title XXI members) shall forward the written request for withdrawal to the AHCCCS Office of Legal Assistance (OLA) or ADHS (non-AHCCCS members) will forward the written request for the withdrawal of the Notice of Hearing to the ADHS Counsel and Legal Support Unit.

G. Processing Request for a Hearing

If the member files a request for hearing, CRS Contractors must ensure that the case file and all supporting documentation is received by the Arizona Health Care Cost Containment System Administration (AHCCCSA), Office of Legal Assistance (OLA) (Title XIX and Title XXI members), or ADHS (non-AHCCCS members) within five (5) business days of receipt of the request. The file provided by CRS Contractors must contain a cover letter that includes:

1. CRS member's name, AHCCCS ID number, address, and phone number (if applicable);
2. Date of receipt of appeal;
3. Summary of the CRS Contractor's actions undertaken to resolve the appeal and summary of the appeal resolution;
4. The CRS member's written request for hearing;
5. Copies of the entire appeal file which includes all supporting documentation including pertinent findings and medical records;
6. Copy of CRS Contractor's Notice of Appeal Resolution; and
7. Other information relevant to the resolution of the appeal.

H. Continuation of Services While the CRS Contractor Appeal and the State Fair Hearing are Pending

1. For the purposes of this section, timely filing means filing on or before the later of the following:
   a. Within ten (10) calendar days after the date that the CRS Contractor mails the Notice of Action, or
   b. The effective date of the action as indicated in the Notice of Action.
2. The CRS Contractor shall continue the member's services if:
   a. The member files the appeal timely;
   b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
   c. The services were ordered by an authorized CRS provider;
   d. The original period covered by the original authorization has not expired; and
   e. The member requests continuation of services.

3. If, at the member's request, the CRS Contractor continues or reinstates the member's services while the appeal is pending, the CRS Contractor shall continue services until one of the following occurs:
   a. The member withdraws the appeal;
   b. Ten (10) calendar days pass after the CRS Contractor mails the Notice of Appeal Resolution to the member, unless the member, within the 10 calendar day time frame, has requested in writing a State Fair Hearing with continuation of benefits until the CRS Contractor decision is reached;
   c. AHCCCS (Title XIX and Title XXI members) or CRSA (non-Title XIX and non-Title XXI members) mails a decision adverse to the member; or
   d. The time-period or service limits of a previously authorized service have been met.
4. If AHCCCS (Title XIX and Title XXI members) or CRSA (non-Title XIX and non-Title XXI members) upholds the CRS Contractors action, the CRS Contractor may recover the cost of the services furnished to the member while the appeal is pending if the services were furnished solely because of the requirements of this policy.

I. Reversed Appeal Resolution

1. If AHCCCS (Title XIX and Title XXI members) or ADHS (non-AHCCCS members) reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, the CRS Contractor shall provide the disputed services promptly, and as expeditiously as the member's health condition requires.
2. If AHCCCS (Title XIX and Title XXI members) or ADHS (non-AHCCCS members) reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the CRS Contractor shall pay the provider for those services.

J. Providers

The grievance process for CRS staff and contracted providers follows the same guidelines as described in Section 8.2, Grievance Process.

K. Tracking and Trending of Member and Provider Grievances

1. Contractors must ensure that member health records, as well as the records described in Section 8.1.B., Records, are available and accessible to authorized staff of their organization and to appropriate State and Federal authorities, or their delegates, involved in assessing quality of care or investigating member or provider quality of care concerns, complaints, allegations of abuse and grievances. Member record availability and accessibility must be in compliance with Federal and State confidentiality laws, including, but not limited to, the Health Insurance Portability and Accountability Act , Pub. L. No. 104-191, (HIPAA) and 42 C.F.R. § 431.300 et seq.
2. Information related to coverage and payment issues must be maintained for at least five (5) years following final resolution of the issue, and must be made available to the member, provider and/or CRSA authorized staff upon request.

3. The CRS Contractor shall log and track all member/provider grievances, denials, appeals, and State Fair Hearings, regardless of who within the organization receives the grievance, appeal, or request for a State Fair Hearing.
4. The grievance, denial, appeal, and State administrative hearing log must be completed using CRSA specified forms and/or databases.
5. The logs and/or databases must be submitted to CRSA by the 15th of the month for the preceding month.

Section 9.1 Types of Records Maintained for CRS Members

A. Types of Records Maintained for CRS Members

The Children's Rehabilitative Services (CRS) Contractors are to maintain medical payment and other related records as defined by this policy for each CRS member as required by this policy, licensing agencies, accreditation organizations, and/or State and Federal laws.

B. Medical and Payment Records

1. Medical records, payment records, and other records required to be maintained by this policy for CRS members are the property of the providers of the record. All CRS members should have a medical record that is maintained by the CRS Contractor or designated subcontractor.
2. CRS Contractors must implement appropriate policies and procedures to ensure that the CRS Contractor and its providers have information required for:
   a. Effective and continuous patient care through accurate medical record documentation of each member's health status, changes in health status, health care needs, and health care services provided,
   b. Quality review, and
   c. Ongoing compliance monitoring of those policies and procedures conducted by the CRS Contractor or its providers through a designated program.
3. CRS Contractors must implement policies and procedures that address medical records and the methodologies to be used to:
   a. Ensure a legible medical record for each enrolled member who has been seen for medical appointments or procedures and/or receive medical/behavioral health records from other providers who have seen the enrolled member.
   b. Confirm that the record is kept up-to-date, well organized, and comprehensive with sufficient detail to promote effective patient care and quality review. A member may have numerous medical records kept by various health care providers that have rendered services to the member. However, the CRS Contractor must maintain a comprehensive record that incorporates at least the following components:
      i. Member identification information on each page of the medical record (i.e., members'name and CRS or Arizona Health Care Cost Containment System (AHCCCS) identification number),
      ii. Documentation of identifying demographics including the member's name, address, telephone number, CRS identification number, gender, age, date of birth, marital status, next of kin, and if applicable, guardian or authorized representative,
      iii. Initial history for the member that includes family medical history, social history, and preventive laboratory

screenings (the initial history for members under age twenty-one (21) should include prenatal care and birth history of the member's mother while pregnant with the member),

iv. Past medical history for all members that includes disabilities, diagnosed anomalies, previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries, emergent/urgent care received, and communicable diseases, including human immunodeficiency virus (HIV),

v. Documentation initialed by a CRS provider to signify review of the following:
   1) Diagnostic information including:
      a) Laboratory tests and screenings,
      b) Radiology and other imaging reports,
      c) Physical examination notes, and
      d) Other pertinent data (e.g., cognitive or other evaluations).
   2) Reports from referrals, consultants, and specialists,
   3) Emergency/urgent care reports,
   4) Hospital discharge summaries, and
   5) Behavioral health referrals and services provided, if applicable.

vi. Immunization records (required for children but recommended for adult members, if available),

vii. Dental history if available and current dental needs and/or services,

viii. Audiology and speech evaluations or related treatment,

ix. Current problem list,

x. Current medications,

xi. Documentation as to whether an adult member has completed advance directives and copy of the directive,

xii. Documentation related to requests for release of medical, payment, other pertinent information and subsequent release,

xiii. Specific release of information process for record requests and disclosures related to communicable disease, including HIV, and substance abuse information,

xiv. Documentation that reflects that diagnostic, treatment, and disposition information related to a specific member was transmitted to the primary care provider (PCP) and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care,

xv. Documentation of a plan for transition from pediatric to adult care beginning at age fourteen (14),

xvi. Application/Referral Packet,

xvii. Condition-specific pertinent flow sheets and appropriate pediatric growth charts,
xviii. Referral information to and from outside agencies, physicians, AHCCCS health plans, and AHCCCS primary care physicians, if applicable, including records of CRS services provided by contracted or subcontracted providers, or non-contracted providers,
xix. Multi-specialty, interdisciplinary team reports,
xx. Audiometric reports,
xxi. Therapy reports (e.g., speech pathology),
xxii. Copies of pharmacy prescriptions and/or medication profile, and
xxiii. Home health summaries.

c. Take into consideration professional and community standards and accepted and recognized practice guidelines.
d. Implement a process to assess and improve the content, legibility, organization, and completeness of members' health records.
e. Require documentation in the members' record showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants (e.g., physicians' assistants) are allowed to provide services.
f. Require that each contracted hospital maintain a medical record on a CRS member served that includes:
   i. Physician or provider orders for the service,
   ii. Applicable diagnostic or evaluation documentation,
   iii. A plan of treatment,
   iv. A periodic summary of the members' progress towards treatment goals,
   v. The date and description of service modalities provided, and
   vi. Signature/initials of the provider for the care rendered.

4. Medical records may be documented on paper or in an electronic format.
   a. For paper documentation, the record must be:
      i. Dated,
      ii. Signed with an original signature and credential,
      iii. Legible and either written in blue or black ink or typewritten, and
      iv. Corrected with a line drawn through the incorrect information, a notation that the incorrect information was an error, the date when the correction was made, and the initials of the person altering the record. Correction fluid or tape is **not allowed**.
   b. For electronic documentation, including e-mail correspondence, there must be a method to:
      i. Indicate the identity of the person making an entry into the record and the date for each entry,
      ii. Ensure that the information is not altered inadvertently, and

iii. Track when, and by whom, revisions to information are made.

c. Electronic medical and payment records, including amended or corrected records, must be maintained by a backup system that conforms to the requirements of this policy and State and Federal law, including the Health Insurance Portability and Accountability Act (HIPAA) Security Regulations at 45 C.F.R. Part 164.

5. CRS Contractors must have written policies and procedures addressing appropriate, confidential, and secure exchange of member information among providers and must conduct reviews to verify the following:
   a. A provider making a referral transmits necessary information to the provider receiving the referral,
   b. A provider furnishing a referral service reports appropriate information to the referring provider,
   c. Providers request information from other treating providers as necessary to provide appropriate and timely care,
   d. Information about services provided to a member by a non-network provider (e.g., emergency services, etc.) is transmitted to the member's PCP,
   e. Member records are transferred to the new provider in a timely manner that ensures continuity of care, and
   f. Member information is shared when a member transfers/partial transfers with another CRS Contractor in a manner that maintains confidentiality while promoting continuity of care.
6. Information from or copies of records may be released only to authorized individuals, and the CRS Contractor must implement a process to ensure that unauthorized individuals cannot gain access to or alter member records.
7. Original and/or copies of medical records must be released only in accordance with Federal laws, State of Arizona laws, CRS policies, and contracts. CRS Contractors must comply with HIPAA requirements and 42 C.F.R. § 431.300 et seq.
8. Upon appropriate release, the CRS Contractor will forward documentation of inpatient and outpatient services to the referring source and/or the primary care physician. The original or a copy of this documentation shall be maintained in the member's medical record at the CRS Contractor's location.
9. All CRS member records shall be pulled for upcoming clinic visits prior to the scheduled clinic.
10. Progress notes shall be filed into the medical record no later than thirty (30) working days from the date of the clinic visit.
11. All medical records, both active and inactive, shall be made available to Children's Rehabilitative Services Administration (CRSA) for research as permitted by State and Federal laws, inspection, and audit purposes.
12. Medical records shall be maintained in an organized, detailed, and comprehensive manner, conforming to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards or standards of other applicable nationally recognized accrediting organizations, and Arizona health care professional standards and

practices.

C. Other Records and Statistical Information

CRSA collects data and information about CRS members to assist in the management and administration of the program. In addition, the CRS Program is subject to a variety of data collection and reporting requirements from regulatory and funding agencies at the State and Federal levels.

Section 9.2 Records Management and Release of Confidential Information

A. Records Management

Records management refers to safeguarding, storage, maintenance, and disclosure of medical information regarding the Children's Rehabilitative Services (CRS) members.

B. Release of Confidential Health Information

1. CRS Contractors and subcontractors must comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-91, Title II and related regulations at 45 C.F.R. Parts 160, 162, and 164; 45 C.F.R. Part 2; A.R.S. § 36-261(A)(5)(k); A.R.S. § 36-661 et seq.; A.R.S. §§ 36-501, 504, and 509; A.R.S. § 12-2291 et seq.; and other State and Federal laws pertaining to disclosure of health information.
2. The Arizona Health Care Cost Containment System Administration (AHCCCSA) is not required to obtain written approval from a CRS member before requesting the member's medical record. AHCCCSA shall be afforded access to all members' medical records whether electronic or paper within twenty (20) working days of receipt of request. The Children Rehabilitative Services Administration (CRSA) may obtain a copy of a member's medical records without written approval from the member if the reason for such request is directly related to the administration of the Arizona Health Care Cost Containment System (AHCCCS) program.

C. Authority for Refusal to Disclose

Any request or demand for medical or payment information, disclosure of which is prohibited by State of Arizona's laws and by this subsection, shall be declined upon the authority of Arizona's laws, the provisions of this subsection, A.R.S. § 36-107 and A.R.S. § 36-136(G). If any employee is compelled, by subpoena or otherwise, to produce such medical information, he/she shall respectfully decline to present or divulge the same, basing his/her refusal upon the provisions of law and this subsection prescribed there under and shall through established administrative channels seek the advice of the appropriate county attorney or the attorney general.

D. Confidentiality of Information Received from or through the Federal Government

Notwithstanding anything in the Arizona Administrative Code, State or Federal laws, or this subsection to the contrary, any medical information contained in the records of this department, the source of which is the Secretary of the U.S. Department of Health and Human Services, or any person acting under him/her, or from any provider of services acting as such pursuant to Pub. L. No. 89-97 any amendments thereto, shall be disclosed only as provided by Federal law and the regulations promulgated there under.

E. Member Access to Medical Records and Payment Records

CRS shall ensure that parents and legal guardians of members less than eighteen (18) years of age and CRS members have access to all of their own medical and payment records during regular business hours, unless circumstances require disclosure at other times for emergency medical care.

F. Storage of Medical Records

CRS Contractors are to provide adequate staffing to ensure that the medical record functions are accomplished efficiently and in a timely manner. This includes pulling records for clinics, physicians, and other authorized individuals, re-filing records accurately, and filing loose material (e.g., X-rays, lab reports, consultation reports, etc.) no later than one (1) month following the clinic visit, and copying medical records with proper authorization as permitted by A.R.S. § 12-2291 et seq. and the HIPAA Privacy Regulations, 45 C.F.R. Parts 160 and 164. There shall be a minimum of one (1) registered health information technologist (RHIT) or individual with the equivalent knowledge and experience in health information management and control in the clinic. The health information management unit will maintain a unit medical record on each individual receiving inpatient, outpatient, or ambulatory surgery services. It should be readily available to the physician and to other individuals as authorized by A.R.S. § 12-2291 et seq, the HIPAA Privacy Regulations, and other State and Federal laws.

G. Storage of Financial Enrollment Records

1. CRS members actively enrolled in CRS shall have all their financial enrollment records maintained at the CRS Contractor sites where services are being provided.
2. CRS members who are terminated from CRS shall have their financial enrollment records maintained at the CRS Contractor site for a minimum for three (3) years.
3. CRS Contractors may submit terminated CRS member financial enrollment records, after three (3) years, to the State of Arizona.
4. CRSA shall retain the records in the State Archives in accordance with CRSA's internal policy and as required by CRSA's contract with AHCCCS.

H. Storage of Application Records

Referrals/applications and all supporting documentation received for the purpose of determining eligibility for CRS must be maintained by the CRS Contractor according to the following timeframes:

1. If an applicant is determined ineligible for any reason and, therefore, is not enrolled in CRS, the referral/application and all supporting documentation must be retained for a period of no less than twenty-four (24) months from the date of CRS eligibility denial/withdrawal of the application. This will ensure that the CRS Contractor has the appropriate documentation in the case of appeal by the applicant and for audit purposes.
2. If the applicant is determined eligible and is enrolled in CRS, the referral/application and all supporting documentation shall be

incorporated into the applicant/member's medical record.

3. The CRS Contractor shall assure that referrals/applications and all supporting documentation are maintained in accordance with this policy, except for the lesser timeframe for retention for those referrals/applications that do not result in enrollment in CRS.

I. Security

Medical records for CRS enrolled individuals shall be housed in the medical records section of the outpatient clinic and shall be separate from the records of the contracting facility. CRS Contractors are obligated to provide security in accordance with HIPAA and JCAHO standards, including physical and record security. The CRS Contractor shall maintain payment records according to HIPAA security, State laws, Federal laws, CRS policies, and contracts.

J. Record Retention

1. Active CRS medical records and source data, as defined by A.R.S. § 12-2291(7), shall be maintained by the providers contracted to render CRS hospital or clinical services in accordance with A.R.S. § 12-2297, accreditation standards, licensure requirements, and other State or Federal law.
2. An individual's medical record is inactive if one of the following conditions applies:
   a. Has not been seen for over two (2) years and does not have a future appointment,
   b. Has expired,
   c. Has moved out of the State of Arizona,
   d. Is no longer medically eligible,
   e. Has reached twenty-one (21) years of age, or
   f. Has disenrolled voluntarily.
3. If the member is an adult, the State of Arizona laws require that medical records be kept for at least six (6) years after the last date of treatment. If the member is a child, medical records must be kept for at least three (3) years after the child's eighteenth birthday or for at least six (6) years after the last date the child received services, whichever date is later. (See A.R.S. § 12-2297).

Section 10.1 Financial Reporting Requirements

A. Financial Reporting Requirements

1. The Children's Rehabilitative Services (CRS) Contractors will have a system in place to produce complete, timely, reliable, and accurate financial records in accordance with contract requirements for financial reporting. CRS Contractors shall design and implement their financial operations system to ensure compliance with Generally Accepted Accounting Principles (GAAP). In addition, CRS Contractors shall file with Children's Rehabilitative Services Administration (CRSA) an annual (more frequently if required by CRSA) Centers for Medicaid and Medicare Services (CMS) approved disclosure statement and related party transactions statement.
2. CRS Contractors receiving State funds shall comply with the certified financial and compliance audit provisions of the Office of Management and Budget (OMB) Circular A-133, whichever is applicable, and the certified financial and compliance audit provisions of A.R.S. § 35-181.03.
3. CRS Contractors are required to provide CRSA with financial and cost information, in the manner specified by CRSA. Types of financial reports include:
   a. Audit report of CRS Contractor's financial statements performed by an independent Certified Public Accountant (CPA);
   b. Other financial, regulatory, or program monitoring reports, as requested by CRSA for program analysis and oversight.
4. Ad hoc, monthly, quarterly, and annual financial reports shall be submitted to CRSA in accordance with the Financial Reporting Guide.

B. Request for Extension of Submission Deadline

1. CRS Contractor shall request approval for an extension for report submission. The requirement to request approval for an extension applies to all reports due to CRSA (financial reporting and quality assurance reporting).
2. As soon as a CRS Contractor is aware that it will be unable to submit a report by the required due date (but at least ten (10) working days prior to the due date), the CRS Contractor must request in writing an approval for an extension. For due dates of reports, CRS Contractors need to refer to their CRSA/CRS Contractor contract (Appendix). The written request for extension for report submission should include the circumstances requiring the extension request and the requested timeframe for the extension.

Section 10.2 Program Reporting Requirements

A. Program Reporting Requirements

1. Children's Rehabilitative Services (CRS) Contractors submit a variety of program reports and other data to Children's Rehabilitative Services Administration (CRSA) to fulfill CRSA compliance responsibilities to funding agencies and to assist CRSA in monitoring and oversight of the CRS program.
2. CRS Contractors shall submit these reports and information in the format and specifications provided by CRSA, as applicable.
3. CRS Contractors shall furnish information and records relating to contract performance to CRSA upon request.

B. Request for Extension of Submission Deadline

1. The Children's Rehabilitative Services (CRS) Contractor shall request approval for an extension for report submission. The requirement to request approval for an extension applies to all reports due to CRSA (financial reporting and quality assurance reporting).
2. As soon as a CRS Contractor is aware that it will be unable to submit a report by the required due date (but at least ten (10) working days prior to the due date) the CRS Contractor must request in writing an approval for an extension. For due dates of reports please refer to your contract (Appendix). The written request for extension for report submission should include the circumstances requiring the extension request and the requested timeframe for the extension.

Section 11.1 Prior Authorization

A. Polices and Procedures

Children's Rehabilitative Services (CRS) Contractors shall have a system for prior authorization including policies and procedure, coverage criteria, and processes for approval/denial of services.

B. Prior Authorization Staff

1. CRS Contractors shall have prior authorization staff that includes Arizona licensed nurse or nurse practitioner, physician, physician or physician's assistant, pharmacist or pharmacy technician with appropriate training to apply CRS medical criteria or make medical decisions. In addition, CRS Contractors shall have a system for maintaining files/documentation in a secured location.
2. CRS Contractors shall use a standardized criterion to make prior authorization decisions for medical necessity. Contractor must ensure consistent application of review criteria and compatible decisions that include Inter-Rater Reliability Criteria and monitoring of all staff involved in the prior authorization process, as well as a plan of action for staff who do not meet criteria and timelines.
3. CRS Contractors' prior authorization staff and CRS Medical Director must attend Inter-rater Reliability Testing at least annually and as requested by Children's Rehabilitative Services Administration (CRSA). CRS Contractors shall have a process for additional education, training, and monitoring of staff. New employees must attend the Inter-rater Reliability Testing within six (6) months of hire.

C. Services Requiring Prior Authorization

1. CRS Contractors shall provide prior authorization for the following services:
   a. All non-emergent inpatient surgeries and medical admissions,
   b. Purchase of durable medical equipment and customized adaptive aids (i.e., any orthotic, prosthetic, hearing aids, eye glasses, high frequency chest wall oscillation (HFCWO) therapy, chest vests, or medical equipment, including custom modified wheelchairs),
   c. Outpatient diagnostic tests (including MRIs) and laboratory services outside CRS Contractor's existing sub-contractors,
   d. Outpatient positron emission tomography scans,
   e. Non-emergent transportation services between CRS contracted hospitals/facilities,
   f. Outpatient ambulatory surgery services,
   g. Implantable bone conduction devices and tactile hearing aids; and,
   h. Non-formulary pharmacy requests.
2. Written policy and procedure for prior authorization shall include the following elements:
   a. CRS Contractors shall have a process to authorize services in a sufficient amount, duration, or scope and pay special attention to Balance Budget Act (BBA) required timelines for the standard and

expedited review process: fourteen (14) calendar days for standard requests versus three (3) working days for expedited requests; with an extension option of an additional fourteen (14) calendar days for both types of requests. Timelines shall be met even if the member has other third-party liability insurance.

b. When a CRS Contractor or provider determines/indicates that the standard response time could seriously jeopardize the member's life, health, or ability to maintain/regain maximum function, an expedited authorization decision is to be made within three (3) working days following receipt of the request for service.

c. CRS Contractors shall have a process for requesting an extension for up to fourteen (14) additional calendar days if either the member or provider requests the extension or CRS Contractor justifies a need for additional information. The extension must be in the member's best interest.

d. Extensions initiated by the CRS Contractor must be documented in writing to the member using the Notification of Extension of Service Authorization Timeframe letter (See Attachment 1).

e. CRS Contractors shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service.

f. On the day the timeframe expires, if a determination is not made, is considered a denial.

g. CRS Contractor may consult with the requesting provider when appropriate.

3. CRS Contractors must have in place criteria for decisions on coverage when the CRS Contractor receives a request for service involving Medicare or other third party payers. The fact that the CRS Contractor is the secondary payer does not negate the CRS Contractor's obligation to render a determination regarding coverage within the timeframes established in section ï2aò Please refer to AHCCCS Contractor Operations Manual Policy 201, Medicare Cost Sharing For Members In Medicare FFS, and Policy 202, Medicare Cost Sharing For Members In Medicare HMO, for additional information regarding payment and cost sharing responsibilities. This manual is available from the AHCCCS Web site at www.ahcccs.state.az.us.

4. CRS program place the responsibility for obtaining prior authorization with the providers. The provider/physician is not guaranteed reimbursement with an authorization number. Documentation shall support the claim/service rendered.

D. Provider Services Requisitions (PSR) Form

1. The provider/physician shall complete a CRS Provider Services Requisition (PSR) form (See Attachment 2) and transmit it to the CRS Contractor site where the service is to be provided.

2. Required Elements on PSR forms.
   A PSR form shall include (at a minimum) the following required elements:
   a. CRS member name and date of birth,
   b. Requesting physician's name and specialty,
   c. Requesting physician's license number,

d. Signature of the requesting physician and date,
e. Service provider's name and specialty if different from requesting physician,
f. CRS diagnosis,
g. Proposed date of service,
h. Proposed service to be provided,
i. Narrative description or supporting documentation/reason of medical necessity for the proposed service,
j. Record date that PSR request is received by CRS Contractor,
k. Type of authorization request (standard or expedited),
l. CRS eligibility checked,
m. Service covered by CRS,
n. Third-Party liability (TPL) insurance checked (if applicable),
o. Complete referral service category (inpatient, ambulatory, physician's office),
p. Name of surgeon and assistant surgeon (if applicable),
q. Place for signature of authorizing medical professional and date of prior authorization approval,
r. Date authorization notice was sent to provider, physician, or facility,
s. Sent by "staff person's name," and
t. Met timelines:
   i. Standard (fourteen (14) calendar days)
   ii. Expedited (three (3) working days)
   iii. Extension (additional fourteen (14) calendar days– final decision within twenty-eight (28) calendar days).

3. CRS Contractor shall have a process for authorizing the PSR that shall determine whether the requested services are medically necessary and appropriate. Decisions on CRS coverage and medical necessity shall be based on the criteria found in the Contractor Policy and Procedure Manual Chapters 5.0 and 6.0.
4. CRS Contractors shall investigate or verify other coverage(s) to which the individual may be entitled, including any requirements for pre-certification by other carriers or liable parties. However, the fact that the CRS Contractor is the secondary payer does not negate the CRS Contractor's obligation to render a determination regarding coverage within the timeframes identified in this policy.
5. CRS Contractors'prior authorization staff (RN, BSN, MD) shall sign and date the authorization for services and send notice of the authorization to the requesting provider when completed.
6. CRS Contractors shall place appropriate limits on services based on a reasonable expectation that the amount of services authorized will achieve the expected outcome.

E. Denial or Reduction of Services

1. CRS Contractors shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service.
2. CRS Contractors shall have procedures for denial of services that include:

a. A clinical review by the CRS Medical Director of decisions to deny authorization on the grounds of medical appropriateness, medical necessity, or CRS coverage.
b. The ability of the CRS Medical Director to consult with another appropriately credentialed CRS physician(s) regarding the requested procedure when the requesting physician challenges the denial.
c. Notification of the requesting provider of any decision to deny, limit, or discontinue authorization of services including appropriate steps for appealing the decision.
d. Proper documentation regarding the reasons behind the adverse decision.
e. Adverse decisions shall only be rendered by the CRS Medical Director, who must sign all denials (See Chapter 11.2, Notice of Action, Notice of Service Authorization Extension, and Notice to ALTCS/Acute Care Provider and Health Plan (only to be applied to eligible and enrolled Title XIX/XXI members)).
f. All CRS Contractorsô prior authorization are subject to retrospective review by CRSA.

Attachment 1

(CRS Contractor Letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.
XXX-XXX-XXXX or (800) XXX-XXXX

Notification of Extension for Service Authorization Timeframe

Date

Name of Member/Guardian
Address
City, State, Zip

RE: *(CRS Member Name, Member #, and AHCCCS #)*

Dear *(Name)*:

We are requiring an extension in the review and approval/denial of your requested (*identify the service).* It may take up to fourteen extra days for the processing of your requested service. In no case will this process take more than 28 days from the date we received the request from your provider. Please call if you have any questions, at XXX-XXX-XXXX, and we will be happy to help you with the call.

On behalf of (*Phoenix, Tucson, Flagstaff, Yuma)* CRS, thank you for your patience and understanding.

If you disagree with our extension of the timeframes, you can make a grievance. You may contact us at INSERT CONTACT NUMBER FOR ORAL GRIEVANCES or you can send a written grievance to INSERT ADDRESS.

If you need help with making a complaint [insert local advocacy organizations] For more information about this notice, you may contact the person whose name and address appears at the top of this notice. You may also refer to your member handbook for more information about the service authorization process.

Sincerely,

XXXXXXXXXXX
Name and credentials
Title

Cc:
Requesting Provider
ALTCS/Acute Care Provider

Attachment 1

(Usar Papel de Membrete del Contratista de CRS)

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy difíciles de leer, favor de llamarnos al xxxxxx y alguien le asistirá.

XXX-XXX-XXXX or (800) XXX-XXXX

Notificación de la Extensión del Horario
Para Autorizaciones De Servicios

Fecha

Nombre de Miembro/Guardián
Dirección
Ciudad, Estado, Código Postal

De: *(Nombre de Miembro, # Miembro de CRS, e # Identificación de AHCCCS)*

Estimado *(Nombre)*:

Estamos requiriendo una extensión en la revisión y la aprobación/negación en su solicitud (identifique el servicio). Puede tomar hasta catorce días adicionales para procesar el servicio solicitado. En ningún caso éste proceso tomará más de 28 días a partir de la fecha que recibimos la petición de su proveedor. Por favor llame si usted tiene cualquier pregunta, al XXX-XXX-XXXX, y estaremos complacidos de ayudarle con su llamada.

Por parte del Contratista de CRS, gracias por su paciencia y comprensión.

Si usted no está de acuerdo con el horario de nuestra extensión, usted puede presentar una queja. Usted puede comunicarse con nosotros al PONER NUMERO DE CONTACTO PARA QUEJAS ORALES o usted puede enviar su queja escrita en PONER DIRECCION.

Si usted necesita ayuda para presentar una queja, [inserte organizaciones de ayuda local o legal.] Para más información sobre este aviso, usted puede comunicarse con la persona de quién el nombre y dirección aparece en la parte superior de este aviso. Usted también se puede referir al manual de los miembros para más información sobre el proceso de la autorización de servicios.

Sinceramente,

XXXXXXXXXXX
Nombre y credenciales
Titulo

Cc:
Proveedor solicitante

Attachment 2

Site _____CRS ID# _____Reviewer _____ Date of Review _____ Mo of PSR _____

Provider Service Requisition Form Required Elements Checklist

Crosswalk these elements to your PSR form to assure all elements are addressed

The CRS Provider Services Requisition (PSR) form shall contain the following demographic information: (Possible Score 100)

☐ CRS member name* ☐ Date of Birth* ☐ Address ☐ Phone
☐ Requesting physician/provider name** ☐ Address ☐ Phone ☐ Specialty**
☐ Requesting physicianôs Arizona medical license number**
☐ Signature of requesting physician or provider*** ☐ Date *
☐ POS (Facility/provider/physician)** ☐ Address ☐ Phone
☐ CRS Diagnosis*** ☐ Procedure(s) if applicable
☐ Supporting documents/reason for the service/medical necessity***

Documentation of: (Total Score = 150 points)

☐ RN Reviewer Name **
☐ Date Received by the CRS Regional Contractor***
☐ Date PSR Requested
☐ Type of Authorization Request: *** ☐ Standard ☐ Expedited
☐ CRS eligibility checked*
☐ Service covered by CRS*
☐ Third Party Liability insurance checked
☐ Type of Service* (in pt, office, ambulatory surgery etc)
☐ Was an extension requested? ☐ If Yes, reason given ☐ Extension letter sent
☐ Date of Prior Authorization Approval**
☐ Signature of authorizing medical professional (RN, BSN)**
☐ Notice sent to provider/physician/facility**
☐ By Staff personôs name*
☐ Met timelines****
- ☐ Standard (14 calendar days)
- ☐ Expedited (3 working days)
- ☐ Extension (additional 14 calendar days-final decision within 28

calendar days)

If PA denied (50)

☐ Reason for denial***

☐ Signature of Medical Director*** ☐ Date *

☐ NOA or Non Coverage by CRS sent ***

- ☐ Notification to physician/provider/facility
- ☐ AHCCCS (if appropriate)

Key to Measure performance Scores

* Every check in the box scores 5 points ___ no mark = 0 points

** Every check in the box scores 10 points ___ no mark = 0 points

*** Every check in the box scores 15 points ___ no mark = 0 points

**** Every check in the box scores 60 points ___ no mark = 0 points FY 08

Section 11.2 Notice of Action, Notice of Service Authorization Extension, and Notice to ALTCS/Acute Care Provider and Health Plan (only to be applied to eligible and enrolled Title XIX/XXI members)

A. Definitions

Action:

1. The denial or limited authorization of a requested service, including the type or level of service;
2. The reduction, suspension, or termination of a previously approved service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide a service in a timely manner, as set forth in contract;
5. The failure of a contractor to act within the time frames required for standard and expedited resolution of appeals and standard disposition of grievances; or
6. The denial of a rural Children's Rehabilitative Services (CRS) member's request to obtain services outside the CRS Contractor's network when the CRS Contractor is the only CRS Contractor in the rural area.

Appeal:
A request for a review of an action.

Notice of Action:
The written notice to the affected member regarding an action by the CRS Contractor.

Service Authorization Request:
A request from a member, his or her representative, or a provider for a service for the member.

B. Mandatory Notice of Action

The CRS Contractor shall send a written Notice of Action to Title XIX/XXI eligible and enrolled members (See Attachment 1, Notice of Action) when:

1. The CRS Contractor makes a decision to deny or issue a limited authorization of a service authorization request, or reduces, suspends, or terminates a previously authorized service.
2. A request for a service from a member who the CRS Contractor has the sole authority to approve or deny. (These are covered services that do not require a physician or qualified health care provider's order. This does not include denials for requests for transportation for purposes other than health care.)

C. Discretionary Notice of Action

The CRS Contractor is not required to issue a notice when:

1. The CRS Contractor issues a denial, suspension, reduction, or termination of a service requested by a member for a service that

requires a provider order. In these circumstances, it is expected that the Contractor timely refer the member to a provider.

2. The CRS Contractor denies, suspends, reduces, or terminates a member's request for a service which the provider has declined to order. A second opinion must be provided in accordance with the federal and state requirements.

D. Requested Notice of Action

Regardless of the category of authorization request, if a Title XIX/XXI enrolled and eligible member requests further recourse when a denial or limited authorization of a requested service is given, a Notice of Action must be provided to the member.

E. Language and Format of the Notice of Action

The CRS Contractor shall ensure that the Notice of Action is in writing and meets the following language and format requirements:

1. The CRS Contractors must use the approved Notice of Action form included at the end of this chapter. The Notice of Action form language and format shall not be altered aside from adding CRS Contractor letterhead, member identification information, and member specific information in the areas identified with the word **"INSERT."**
2. The Notice of Action shall be available in each non-English language spoken by a significant number or percentage of members or potential members in the contractor's geographic service area as established by contract. The Notice of Action shall explain that free oral interpretation services are available to explain the Notice of Action for all non-English languages.
3. In understandable language, the Notice of Action must clearly explain the service being denied, suspended, reduced, or terminated and the reason for the action.
4. When any CRS Contractor forwards a request for a service to another CRS Contractor, the notification shall be in writing and associated documents supporting that request shall be included with the forwarded documents.

F. Requested Service not Medically Necessary

1. A general statement that a requested service is not medically necessary, without an explanation of why the service is not medically necessary, is unacceptable as a reason for the action.
2. If a CRS Contractor determines that a service is not medically necessary, the CRS Contractor must:
   a. Cite to the relevant regulation as the legal basis for the action and state the regulation in easy to understand terms; and
   b. Explain why a denied/reduced service is not medically necessary in language that is easily understood by the member. Refer to Section II of the Arizona Health Care Cost Containment System (AHCCCS) "Guide To Language In Notice Of Action" for examples of when medical necessity is appropriately used in denying/limiting services.

G. Content of the Notice of Action

1. The CRS Contractor shall ensure that the Notice of Action explains the following (See AHCCCS Contractor Operations Manual, Section 409, and Notices of Action, and Section 414, Content of Notices of Action):
   a. The requested service,
   b. The reason/purpose of the requested service,
   c. The action the CRS Contractor has taken or intends to take with respect to the service request,
   d. The reason(s) for the action, including factual findings about the member's condition that were the basis for the CRS Contractor's action,
   e. The legal basis for the action, which includes references to Federal and State law on which the CRS Contractor based the action,
   f. The location of where members can find copies of the legal basis, e.g., local public library, law libraries, Web page with links to legal authorities, and etc.,
   g. The member's right to file an appeal with the CRS Contractor,
   h. The procedures for exercising the right to file an appeal,
   i. The legal resources for members for help with appeals, as prescribed by the Arizona Health Care Cost Containment System (AHCCCS),
   j. The circumstances under which an expedited resolution is available and how to request it, and
   k. The circumstances under which a member has a right to have services continue pending resolution of the appeal, how to request that services be continued, and the circumstances under which the member is liable for the costs of services.
2. The CRS Medical Director must sign the Notice of Action letter.
3. In the Notice of Action letter, the CRS Contractor must acknowledge the member's right to be assisted by a representative, including an attorney. The CRS Contractor's appeals process must register the existence of the third party, and the CRS Contractor must ensure that the required communications related to the appeals process occur between the CRS Contractor and the representative. The member's representatives, upon request, must be provided access to documentation relating to the decision under appeal. Consistent with federal privacy regulations, the CRS Contractor must make reasonable efforts to verify the identity of the third party and the authority of the third party to act on behalf of the member. This verification may include requiring that the representative provide a written authorization signed by the member. However, if the CRS Contractor questions the authority of the representative or the sufficiency of a written authorization, the CRS Contractor must promptly communicate that to the representative.

H. General Requirements

1. The CRS Contractor that is responsible for the action is also responsible for providing the Notice of Action.

2. Timeframes for the Provision of the Notice of Action:
   a. When authorization for a requested service is denied, a Notice of Action shall be provided to the Title XIX/XXI eligible and enrolled recipient as expeditiously as the health condition requires, but not later than:
      i. Fourteen (14) calendar days for standard authorization denials; or
      ii. Within three (3) working days for expedited authorization decisions.
      iii. Authorization decisions may be extended for up to 14 days, as described in Contractor Policy and Procedure Manual Section 11.1, Prior Authorization (See Attachment 2, Notification of Extension for Service Authorization Timeframe).
   b. When continued authorization for a requested covered service is terminated, reduced, or suspended, a Notice of Action shall be provided to the Title XIX/XXI eligible and enrolled recipient at least ten (10) days prior to the date of the intended action, or at least five (5) days prior to the date of the intended action in the case of suspected fraud. The CRS Contractor may shorten the period of advance notice to two (2) days before the date of intended action for the termination of non-emergency inpatient services, as a result of the denial of a continued stay request. A Notice of Action may be delivered on the date of action under the following circumstances:
      i. Death of recipient,
      ii. Written statement by recipient that services are no longer wanted,
      iii. Recipient is age 21-64 and in an institution for mental disease (IMD) for over thirty (30) days,
      iv. Recipient is an inmate of a public institution not receiving federal financial participation,
      v. Recipient's whereabouts are unknown and post office returns mail indicating no forwarding address, or
      vi. Acceptance into another State's Medicaid Program.
   c. Delivery of the Notice of Action
      The Notice of Action must be:
      i. Sent to the Member or their legal or authorized representative, and copied to the Arizona Long Term Care System (ALTCS)/Acute Care Contractor and/or the requesting provider, as appropriate.
      ii. A copy of the Notice of Action must be retained in the clinic record.

I. ALTCS/Acute Care Contractor Review of Request for Services

Requests received by an ALTCS/Acute Care Contractor for a service to a Title XIX/XXI eligible and enrolled CRS recipient:

1. The ALTCS/Acute Care Contractor shall conduct a review of the request for medical necessity.

2. If the ALTCS/Acute Care Contractor believes the service is not medically necessary, the ALTCS/Acute Care Contractor shall contact a CRS Medical Director for a second opinion to determine whether CRS concurs with the ALTCS/Acute Care Contractor's determination. CRS shall determine whether the requested service is medically necessary and shall respond to the ALTCS/Acute Care Contractor within (one) 1 working day. The entire process shall occur within the standard authorization timeframe of fourteen (14) days.
3. If the CRS Medical Director concurs that the service is not medically necessary, the ALTCS/Acute Care Contractor shall deny the request and send a Notice of Action to the member.
4. If the CRS Medical Director determines that the service is medically necessary, CRS and the ALTCS/Acute Care Contractor shall follow the process in Section I(5).
5. If the ALTCS/Acute Care Contractor determines the service is medically necessary and believes that the service is a CRS covered benefit, the ALTCS/Acute Care Contractor shall:
   i. Notify CRS of the request; and
   ii. Simultaneously inform the member that a fourteen (14) day extension is being taken (a decision must be rendered no later than twenty-eight (28) days from the date the request was initiated) to provide the decision to the member and provider.

J. CRS Review of Request for Services

CRS shall review the request for a service.

1. If CRS approves the services:
   a. The CRS Contractor will notify the ALTCS/Acute Care Contractor.
   b. The ALTCS/Acute Care Contractor shall notify the member in writing that the service will be provided by CRS and direct the member to CRS.
   c. The ALTCS/Acute Care Contractor shall assist the member in contacting CRS.
2. If CRS denies the services:
   a. The CRS Contractor will send **no** notice to the member.
   b. The CRS Contractor will notify the ALTCS/Acute Care Contractor in writing of its decision (See Attachment 3, Notice to ALTCS/Acute Care Contractor of Non-Coverage by Children's Rehabilitative Services).
   c. The notification shall also inform the Medical Director of the ALTCS/Acute Care Contractor of the right to appeal the decision by filing a Request for Review in writing with the CRS Medical Director no later than ten (10) business days after the decision.
   d. The ALTCS/Acute Care Contractor will:
      i. Process the request within the twenty-eight (28) day timeframe of the original request.
      ii. Provide requested services as ordered, or provide limited authorization of the request. If limited authorization is provided, the Acute Care Contractor shall issue a Notice of Action to the member.

e. Upon receipt of the Request for Review by CRS:
   i. The CRS Medical Director shall issue a written decision to the ALTCS/Acute Care Contractor no later than ten (10) business days from the date of the receipt of the Request for Review (See Attachment 4, Notice of Decision by CRS on ALTCS/Acute Care Contractor Request for Review).
   ii. The CRS decision shall advise the ALTCS/Acute Care Contractor Medical Director that the ALTCS/Acute Care Contractor may file a request for hearing with the AHCCCS Administration within thirty (30) days of receipt of the CRS decision in the event that the ALTCS/Acute Care Contractor disagrees with the CRS decision.
   iii. If the AHCCCS Hearing Decision determines that the service should have been provided by CRS, the CRS Contractor shall be financially responsible for the costs incurred by the ALTCS/Acute Care Contractor in providing the service.

K. Timeframe for Request and Review of Notice of Action

1. The timing of the above steps shall be as follows:
   a. Day 1 (day request is received) through Day 5 - ALTCS/Acute Care Contractor review, if not a CRSA covered benefit and approve or deny the request;
   b. Day 6 - Fax to CRS with medical documentation to support the request;
   c. Day 7 through Day 15 - CRS review;
   d. Day 16 - CRS to fax or call the ALTCS/Acute Care Contractor with the decision. If CRS denies the request, CRS proceeds as in J(2).. If CRS authorizes the service, CRS and the ALTCS/Acute Care Contractor proceeds as in J(1).; and,
   e. Day 17 through Day 28 ï If CRS denies the request; ALTCS/Acute Care Contractor authorizes the service. If the ALTCS/Acute Care Contractor provides limited authorization of the request, issue a Notice of Action. ALTCS/Acute Care Contractor may follow the Request for Review guidelines. (Refer to the process in I(5))
2. The ALTCS/Acute Care Contractor is responsible for rendering the decision no later than the total twenty-eight (28) day timeframe beginning when the date request is received. If CRS fails to issue an authorization decision within the above timeframe, the ALTCS/Acute Care Contractor shall authorize the request and provide the service. Afterward, the ALTCS/Acute Care Contractor may file a request for hearing with the AHCCCS Administration within thirty (30) days from the date the authorization decision should have been issued by CRS.

L. Request Received by an ALTCS/Acute Care Contractor for a Member Who is not Enrolled with CRS.

1. If the ALTCS/Acute Care Contractor reasonably believes that the member

has a CRS condition and the service is related to that condition, the ALTCS/Acute Care Contractor shall:

a. For urgent requests:
   i. Initiate a Medical Director to Medical Director communication for urgent requests.
   ii. If the request meets medical necessity guidelines and is date sensitive, the ALTCS/Acute Care Contractor must review and follow medical guidelines to assure that medically necessary care is not delayed.

b. For non-urgent requests:
   i. The ALTCS/Acute Care Contractor shall refer the member to CRS.
   ii. The ALTCS/Acute Care Contractor shall issue a Notice of Action to the member denying the service referencing that CRSA may be the responsible entity for the service and that the member must establish eligibility with CRS.
   iii. The ALTCS/Acute Care Contractor shall assist the member in contacting CRS as necessary. (Refer to the process as a Request for Review in J.)
   iv. The ALTCS/Acute Care Contractor will monitor the CRS application to ensure that the process is completed by the member's legal guardian.
   v. The ALTCS/Acute Care Contractor will monitor the CRS application outcomes in order to ensure ordered medically necessary care is provided.
   vi. In the event that CRS determines that the member does not meet the medical eligibility requirement for participating in the CRS program, CRS shall inform the referring physician and the applicable ALTCS/Acute Care Contractor, in writing, of the denial and the reason for the denial within five (5) working days of the denial.

M. Request Received by CRS for AHCCCS Members Who are CRS Members

1.. CRS shall determine if the request is a CRS covered benefit.

2.. If CRS determines the request is not a CRS covered benefit:

a. CRS will send **no** notice to the member, but shall notify the ALTCS/Acute Care Contractor in writing (See Attachment 5, Notice to AHCCCS Health Plan/Program Contractor of Non-Coverage by Children's Rehabilitative Services).

b. Simultaneously, CRS shall inform the member in writing that:
   i. A fourteen (14) day extension is being taken (not to exceed twenty-eight (28) days) (See Attachment 6, Notification of Extension for Referral to ALTCS/Acute Care Contractor);
   ii. The service request is not a CRS covered benefit; and,
   iii. That the request is being referred to the member's primary AHCCCS plan.

c. CRS shall direct the member to the ALTCS/Acute Care

Contractor.

d. CRS shall assist the member in contacting the ALTCS/Acute Care Contractor.

3. ALTCS/Acute Care Contractor shall review the request and:
   a. Shall conduct a review of the request for medical necessity.
      i. If the ALTCS/Acute Care Contractor determines that the service is not medically necessary, the Contractor shall deny the request and send a Notice of Action to the member and notify CRS of its decision.
      ii. If the request is determined medically necessary and is not a CRS covered benefit, the Contractor shall authorize the service and notify CRS in writing of its decision.
      iii. If the request is determined medically necessary and is presumed to be a CRS covered benefit, the ALTCS/Acute Care Contractor shall authorize the service and may file a request for hearing with the AHCCCS Administration within thirty (30) days of receipt of the CRS decision.
   b. The timing of the above steps in M(3)(a)(i)-(iii) shall be as follows:
      i. Day 1 (day request is received) through Day 5 ï CRS review;
      ii. Day 6 ï Fax to ALTCS/Acute Care Contractor with medical documentation to support request;
      iii. Day 7 through Day 15 ï ALTCS/Acute Care Contractor review for medical necessity; and,
      iv. Day 16 through Day 17 - ALTCS/Acute Care Contractor
      v. Day 18 through 28 ï ALTCS/Acute Care Contractor authorizes the services or issues a Notice of Action to the member when a requested service is denied or a limited authorization is given.

Attachment 1

(CRS Contractor Letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at *(code)-phone #* and someone will assist you.

Notice of Action

Date

To: Name
Address
City, State Zip

From:

You have asked that **INSERT**: Name of the Contractor approve: **INSERT**: Describe services requested on behalf of the member in easily understood terms. We have reviewed your request and decided that: **INSERT**: Describe action taken (or intended to be taken) by Contractor, including the relevant dates, in member specific terms and in easily understood language.

Our decision is based on the following reasons**: INSERT:** The explanation of the Contractorôs decision must be complete and in commonly understood language. It must specify the relevant laws, rules, policies, etc. for the action. The explanation must also be both member and fact specific, describing the memberôs condition and the reasons supporting the Contractor decision. Generic statements are not adequate. Any decisions to deny or reduce a service authorization request must be made by a health care professional who has appropriate clinical expertise in treating the memberôs condition or disease.

You can ask us to look at our decision again. This is called an appeal. You can have someone help you appeal. Also, your doctor or other health care provider can appeal for you if you write telling us so. If you appeal you must contact us by **INSERT DATE:** no later than 60 days after the date of this Notice*. You can write or call us to appeal*. If you write your appeal, it must be received by **INSERT DATE**: 60 days from the date of the Notice.

Before we make our decision, you can give us any information that you think will be helpful. You can ask to set up a meeting so that you can give us the information in person, or you can give it to us in writing. You can also see your case file, including

medical records and other information about your appeal, before you give us information and before we decide the appeal. After we review your appeal, we will send you our decision in writing. This decision is called the Notice of Appeal Resolution.

We will make a decision within 30 days. However, you may ask for a faster review of your appeal. This is called an "expedited appeal." You can ask for a faster review if your/your child's life or health could be in danger or your/their ability to attain, maintain or regain maximum function would be damaged by waiting the normal 30 days for a decision on your appeal. If your health care provider tells us this, the appeal will be decided in 3 working days. You may also ask us to decide the appeal in 3 working days. If you ask us yourself and we agree, we will make a decision in 3 working days. If you ask for a faster review (expedited appeal), tell us how your health will suffer if we take 30 days to decide your appeal. If we do not agree that a faster review is needed, we will write you within 2 days, and we will also try to call you. Then we will decide your appeal within 30 days.

For all appeals, up to 14 more days may be taken to make a decision on your case. This is called an extension. If we want an extension we will tell you why it is needed. If you want an extension, you can you can ask for it by writing or calling us.

TO REQUEST CONTINUED BENEFITS DURING THE INSERT: Name of Contractor APPEALS PROCESS

You can ask that the services listed in this letter continue while we make a decision. If you want those services to continue, you must say so when you appeal. This applies if we are stopping or reducing an approved service ordered by your doctor or other health care provider that you are receiving now. This also applies to a service we have denied if the doctor or other health care provider says that the service is a necessary continuation of a service that was approved before. Your service will only be continued if you appeal by **INSERT DATE:** (the later of: 10 days from the date of the Notice OR the intended date of the action). If you do not win your appeal, you will be responsible for paying for these services provided during the appeal.

If you have any questions about filing an appeal or if you need help, you can call us at **INSERT**: phone number**.** Please send your written appeal to**: INSERT:** address.

Sincerely,

INSERT: Signature of CRS Medical Director

INSERT: Name of CRS Medical Director

cc. AHCCCS Plan
PCP/provider

CRSA
Chart copy

Attachment 1

(*Usar Papel de Membrete del Contratista de CRS*)

Si usted tiene dificultades leyendo este aviso porque las -letras son demasiado pequeñas 0 las palabras son muy difícil para leer, favor de llamarnos y alguien le asistirá.
(Code)-Phone # or (800) --- ---
http://www.ahcccs.state.az.us/Regulations/OSPPolicy/default.asp

Aviso de Acción

Fecha

A: Nombre
Dirección
Ciudad, Estado, Código Postal

De:

Usted ha pedido que **PONER:** Nombre del Contratista apruebe: **PONER:** En términos fáciles de entender, describa los servicios que fueron solicitados a nombre del miembro. Se ha revisado su petición y se decidió esto: **PONER:** Describa la acción tomada (o que intenta ser tomada) por el Contratista, incluyendo las fechas relevantes, en términos específicos para el miembro y en un lenguaje fácil de comprender.

Nuestra decisión esta basada en las siguientes razones: **PONER:** La explicación de la decisión del Contratista debe ser completa y en un lenguaje comúnmente entendible. Debe especificar las leyes relevantes, las reglas, las pólizas, etc. para la acción. Esta explicación debe especificar los hechos y también ser concreta para el miembro, describiendo la condición del miembro y las razones apoyando la decisión tomada por el Contratista. Las declaraciones genéricas no son adecuadas. Cualquier decisión de negar o reducir una solicitud para la autorización del servicio debe ser hecha por un profesional del cuidado de la salud que tiene pericia clínica apropiada para tratar la condición o enfermedad del miembro.

Usted puede pedir que la decisión sea revisada nuevamente. Esto se llama una apelación. Usted puede obtener ayuda de otra persona con su apelación. También, su doctor u otro proveedor de cuidado de salud pueden hacer una apelación por parte suya, si usted nos deja saber por escrito que eso va pasar. Si usted decide hacer una apelación tiene que avisarnos en **PONER FECHA:** a no más tardar 60 días después de la fecha de este Aviso. *Usted puede hacer su apelación enviándonos una carta o hablándonos por teléfono.* Si usted decide escribir su apelación, debe de ser recibida para **PONER FECHA:** 60 días desde de la fecha de este Aviso.

Antes de que se tome una decisión usted puede dar cualquier información que crea que sea beneficiosa. Usted puede pedir que se haga una reunión, para darnos la información en persona, o puede enviar la información por escrito. Antes de tomar una decisión sobre su apelación, y antes de darnos información adicional, usted tiene el derecho de revisar su archivo, incluyendo los expedientes médicos y otra información sobre su apelación. Después de revisar su apelación, se le enviará la decisión por escrito. Esta decisión se llama Aviso de la Resolución de la Apelación.

Tomaremos una decisión en un plazo de 30 días. Sin embargo, usted puede pedir una revisión más rápida para su apelación. Esto se llama ñApelación Aceleradaò
Usted puede solicitar una revisión mas rápida si su salud o su vida/o la de su hijo(a) estuviera en peligro o si la capacidad de usted/ellos de lograr, mantener o la recuperación de la función normal se deteriorara, por esperar los 30 días que normalmente se puede tomar para hacer una determinación por su apelación. Si su proveedor de cuidado de salud nos informa que esto puede suceder, la apelación será decidida dentro de 3 días laborales. Usted también tiene el derecho de pedirnos que tomemos una determinación sobre su apelación dentro de 3 días laborales. Si usted mismo nos pide tomar una decisión más rápida y si estamos de acuerdo, tomaremos una decisión en 3 días laborales. Si usted pide una revisión más rápida (apelación acelerada), explíquenos como sufrirá su estado de salud, si nos tardamos los 30 días para hacer una decisión para su apelación. Si no estamos de acuerdo que se necesita hacer una revisión rápida, le avisaremos por medio escrito dentro de 2 días, y también trataremos de hablarle por teléfono. Luego decidiremos dentro de los 30 días sobre su apelación.

Para todas las apelaciones, 14 días más pueden ser tomados para hacer una decisión sobre su caso. Esto se llama una extensión. Si queremos una extensión le explicaremos por qué es necesario. Si usted quiere una extensión, puede pedirlo, llamándonos por teléfono o escribiéndonos.

PARA SOLICITAR QUE SUS BENEFICIOS CONTINUEN DURANTE EL PROCESO DE APELACIÓN DE <u>PONER: Nombre de Contratista</u>

Usted puede pedir que los servicios mencionados en esta carta continúen mientras llegamos a una decisión. Si usted quiere que los servicios continúen, debe decirlo cuando haga su apelación. Esto se aplica cuando reducimos o terminamos los servicios aprobados y ordenados por su doctor u otro proveedor de salud que usted esta recibiendo en este momento. También esto se aplica para los servicios que le hemos negado, si su doctor u otro proveedor de salud dice que el servicio necesitado es una continuación de un servicio que fue aprobado antes. Su servicio será continuado solamente, si usted solicita una apelación en **<u>PONER FECHA:</u>** <u>(No mas tardar: 10 días a partir de la fecha del aviso ó de la fecha prevista de la acción)</u>. Si usted no gana su apelación, usted será responsable en pagar los servicios proveídos durante su apelación.

Si usted necesita ayuda o tiene preguntas sobre como solicitar una apelación, nos puede llamar al **PONER:** numero de teléfono. Envié por favor su apelación escrita al: **PONER:** dirección.

Respetuosamente,

PONER: Firma del Director Médico

PONER: Nombre del Director Médico

dd. Plan de AHCCCS
Doctor/proveedor
CRSA
Copia de archivo (not the translation of chart copy, instead it states copy of archives)

Attachment 2

(CRS Contractor Letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.
XXX-XXX-XXXX or (800) XXX-XXXX

Notification of Extension for Service Authorization Timeframe

Date

Name of Member/Guardian
Address
City, State, Zip

RE: *(CRS Member Name, Member #, and AHCCCS #)*

Dear *(Name)*:

We are requiring an extension in the review and approval/denial of your requested (*identify the service).* It may take up to fourteen extra days for the processing of your requested service. In no case will this process take more than 28 days from the date we received the request from your provider. Please call if you have any questions, at XXX-XXX-XXXX, and we will be happy to help you with the call.

On behalf of (*Phoenix, Tucson, Flagstaff, Yuma)* CRS, thank you for your patience and understanding.

If you disagree with our extension of the timeframes, you can make a grievance. You may contact us at INSERT CONTACT NUMBER FOR ORAL GRIEVANCES or you can send a written grievance to INSERT ADDRESS.

If you need help with making a complaint [insert local advocacy organizations] For more information about this notice, you may contact the person whose name and address appears at the top of this notice. You may also refer to your member handbook for more information about the service authorization process.

Sincerely,

XXXXXXXXXXX
Name and credentials
Title

Cc:
Requesting Provider
ALTCS/Acute Care Provider

Attachment 2

(Usar Papel de Membrete del Contratista de CRS)

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy difíciles de leer, favor de llamarnos al xxxxxx y alguien le asistirá.

XXX-XXX-XXXX or (800) XXX-XXXX

Notificación de la Extensión del Horario Para Autorizaciones De Servicios

Fecha

Nombre de Miembro/Guardián
Dirección
Ciudad, Estado, Código Postal

De: *(Nombre de Miembro, # Miembro de CRS, e # Identificación de AHCCCS)*

Estimado *(Nombre)*:

Estamos requiriendo una extensión en la revisión y la aprobación/negación en su solicitud (identifique el servicio). Puede tomar hasta catorce días adicionales para procesar el servicio solicitado. En ningún caso éste proceso tomará más de 28 días a partir de la fecha que recibimos la petición de su proveedor. Por favor llame si usted tiene cualquier pregunta, al XXX-XXX-XXXX, y estaremos complacidos de ayudarle con su llamada.

Por parte del Contratista de CRS, gracias por su paciencia y comprensión.

Si usted no está de acuerdo con el horario de nuestra extensión, usted puede presentar una queja. Usted puede comunicarse con nosotros al PONER NUMERO DE CONTACTO PARA QUEJAS ORALES o usted puede enviar su queja escrita en PONER DIRECCION.

Si usted necesita ayuda para presentar una queja, [inserte organizaciones de ayuda local o legal.] Para más información sobre este aviso, usted puede comunicarse con la persona de quién el nombre y dirección aparece en la parte superior de este aviso. Usted también se puede referir al manual de los miembros para más información sobre el proceso de la autorización de servicios.

Sinceramente,

XXXXXXXXXXX
Nombre y credenciales
Titulo

Cc:
Proveedor solicitante

Attachment 3

(CRS Contractor Letterhead)

Notice to ALTCS/Acute Care Contractor of Non-Coverage by Children's Rehabilitative Services

To (ALTCS/Acute Care Contractor)

Date:

Re: *(Member name, CRS #, AHCCCS #)*

An AHCCCS Health Plan asked that (name of CRS clinic) approve: *(describe services including date requested)*

The CRS Medical Director has reviewed and denied the requested service as not covered by CRS.

This decision is based on the following: *(Any decisions to deny or reduce a service must be made by a physician, who has appropriate clinical expertise in treating the member's condition or disease. The explanation must be complete and specify the relevant laws, rules, policies etc. for the action. The explanation must also be both member and fact specific, describing the member's condition and the reasons supporting the denial.)*

If you disagree with this decision, you have the right to appeal the decision and file a Request for Review in writing with the CRS Medical Director no later than 10 business days after receipt of this notice.

Sincerely,

_____

CRS Medical Director

Cc: Requesting Physician/Provider
File copy
CRSA

Attachment 3

(*Usar Papel de Membrete del Contratista de CRS*)

Aviso al Contratista del Programa de ALTCS/Acute Care
No Proporcionar Cobertura de Servicios por parte de CRS

A: Nombre del Contratista

Fecha:

Acerca de: *(Nombre del Miembro, # Miembro de CRS, e # Identificación de AHCCCS)*

Un proveedor de CRS o un miembro de CRS ha pedido que (*nombre de la clínica de CRS*) apruebe: (*describa los servicios solicitados, incluyendo la fecha que fueron solicitados*).

El Director Médico del Contratista de CRS ha revisado y negado el servicio solicitado por que no es un servicio que esta cubierto por CRS.

Esta decisión se basa en lo siguiente: *(Cualquier decisión para negar o para reducir un servicio debe ser hecha por un médico, el cual tiene pericia clínica apropiada en tratar la condición o la enfermedad del paciente o miembro. La explicación debe ser completa y especificar las leyes relevantes, las reglas y las pólizas, etc. para la acción tomada. Esta explicación debe especificar los hechos y también ser concretamente para el miembro, describiendo la condición del mismo y las razones que apoyen la negación de este servicio.)*

Si usted no esta de acuerdo con esta decisión, tiene el derecho de apelar la decisión y someter por escrito una Solicitud para Revisión al Director Médico del Contratista de CRS, a no mas tardar 10 días laborales después de recibir esta carta.

Sinceramente,

_____

Director Médico

C.C: Solicitud enviada por parte del Doctor/Proveedor
Copia de Archivo
CRSA

Attachment 4

(CRS Contractor Letterhead)

Notice of Decision by CRS on ALTCS/Acute Care Contractor Request for Review

Date

To: ALTCS/Acute Care Contractor Name
Address

Re: (*Member name, CRS Member #, and AHCCCS ID#*)

Dear: (*Plan Medical Director*)

We received your Request for Review dated _____ asking us to review our decision to _____.

After reviewing our original decision, we have decided (*that the first decision was right/* ***or****/ to change our decision to* _____.) We have made this decision based on *(Please include the legal citations or authorities supporting the determination.)*

If you do not agree with our decision you may file a request for a hearing with the AHCCCS Administration within 30 days of receipt of this letter.

If you have questions, please call us at *(XXX) XXX-XXXX.*

Sincerely,

_____
CRS Medical Director

Attachment 4

(Usar Papel de Membrete del Contratista de CRS)

Aviso de la Decisión por CRS sobre su Solicitud para una Revisión para el Plan de Salud AHCCCS/Contratista del Programa

Fecha

A: Nombre del Plan de Salud
Dirección

Re: *(Nombre del Miembro, # Miembro de CRS, e # Identificación de AHCCCS)*

Estimado: *(Director Médico del Plan)*

Hemos recibido su solicitud para una revisión, con fecha _____, pidiéndonos considerar nuestra decisión sobre_____.

Después de examinar la decisión original, se ha determinado *(que la primera decisión estaba correcta o/ cambiar nuestra decisión a _____.)* Se ha tomado ésta medida basado en lo siguiente *(Incluya por favor las citaciones legales o las autoridades que apoyen la determinación.)*

Si usted no esta de acuerdo con nuestra decisión, puede solicitar una audiencia con la Administración de AHCCCS dentro de los 30 días siguientes a que reciba esta carta.

Si usted tiene preguntas, favor de llamarnos al *(XXX) XXX-XXXX*.

Sinceramente,

_____
Director Médico del Contratista de CRS

Attachment 5

(CRS Contractor Letterhead)

Notice to AHCCCS Health Plan/Program Contractor of Non-Coverage by Children's Rehabilitative Services

To (AHCCCS Plan name)

Date:

Re: (Member Name, CRS #, AHCCCS #)

A CRS provider or member has asked that (*name of CRS clinic*) approve: (*describe services including date requested*)

The CRS Medical Director has reviewed and denied the requested service as not covered by CRS.

This decision is based on the following: (*Any decisions to deny or reduce a service must be made by a physician, who has appropriate clinical expertise in treating the member's condition or disease. The explanation must be complete and specify the relevant laws, rules, policies etc. for the action. The explanation must also be both member and fact specific, describing the member's condition and the reasons supporting the denial.*)

If you disagree with this decision, you have the right to file a Request for Review in writing with the CRS Medical Director no later than 10 business days after receipt of this notice.

Sincerely,

_____
CRS Medical Director

cc: Requesting Physician/Provider
File copy
CRSA

Attachment 5

(*Usar Papel de Membrete del Contratista de CRS*)

Aviso de la Decisión por CRS sobre su Solicitud para una Revisión para el Plan de Salud AHCCCS/Contratista del Programa

Fecha

A: Nombre del Plan de Salud
Dirección

Re: *(Nombre del Miembro, # Miembro de CRS, e # Identificación de AHCCCS)*

Un proveedor de CRS o un miembro de CRS ha pedido que (*nombre de la clínica de CRS*) apruebe: (*describa los servicios solicitados, incluyendo la fecha que fueron solicitados*).

El Director Médico del Contratista de CRS (*nombre de la región*) ha revisado y negado el servicio solicitado por que no es un servicio que esta cubierto por CRS.

Esta decisión se basa en lo siguiente: *(Cualquier decisión para negar o para reducir un servicio debe ser hecha por un médico, el cual tiene pericia clínica apropiada en tratar la condición o la enfermedad del paciente o miembro. La explicación debe ser completa y especificar las leyes relevantes, las reglas y las pólizas, etc. para la acción tomada. Esta explicación debe especificar los hechos y también ser concretamente para el miembro, describiendo la condición del mismo y las razones que apoyen la negación de este servicio.)*

Si usted no esta de acuerdo con esta decisión, tiene el derecho de apelar la decisión y someter por escrito una Solicitud para Revisión al Director Médico *del Contratista* de CRS, a no mas tardar 10 días laborales después de recibir esta carta.

Sinceramente,

_____
Director Médico del Contratista de CRS

C.C: Solicitud enviada por parte del Doctor/Proveedor
Copia de Archivo
CRSA

Attachment 6

(CRS Contractor Letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Notification of Extension for Referral to ALTCS/Acute Care Contractor

Date

Name of Member/Guardian
Address
City, State, Zip

RE: *(CRS Member Name, Member #, and AHCCCS #)*

Dear *(Name)*:

We are forwarding your request for (*identify the service)* to your AHCCCS Plan. It may take up to fourteen extra days for your Plan to receive and process the request. In no case will this process take more than 28 days from the date we received the request from your provider. Please call your AHCCCS Plan if you have any questions, or, if you do not know who to contact at your AHCCCS Plan, please call us at XXX-XXX-XXXX, and we will be happy to help you with the call.

On behalf of the CRS Contractor, thank you for your patience and understanding.

If you disagree with our extension of the timeframes, you can make a grievance. You may contact us at INSERT CONTACT NUMBER FOR ORAL GRIEVANCES or you can send a written grievance to INSERT ADDRESS.

If you need help with making a complaint [insert local advocacy organizations] For more information about this notice, you may contact the person whose name and address appears at the top of this notice. You may also refer to your member handbook for more information about the service authorization process.

Sincerely,

XXXXXXXXXXX
Name and credentials
Title

Cc:
Requesting Provider
ALTCS/Acute Care Contractor

Attachment 6

(Usar Papel de Membrete del Contratista de CRS)

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy difíciles de leer, favor de llamarnos al xxxxxx y alguien le asistirá.
XXX-XXX-XXXX or (800) XXX-XXXX

Notificación de la Extensión para la Remisión al ALTCS/Acute Care Contractor

Fecha

Nombre de Miembro/Guardián
Dirección
Ciudad, Estado, Código Postal

De: *(Nombre de Miembro, # Miembro de CRS, e # Identificación de AHCCCS)*

Estimado *(Nombre)*:

Hemos enviado su petición para (*identifique el servicio*) a su plan de AHCCCS. Puede tomar hasta catorce días adicionales para que su Plan reciba y procese la petición. En ningún caso este proceso tomara más de 28 días a partir de la fecha que recibimos la petición de su proveedor. Por favor llame a su plan de AHCCCS si tiene cualquier pregunta, o, si no sabe con quién comunicarse al plan de AHCCCS, por favor llame al XX-XXX-XXXX, y estaremos complacidos de ayudarle con su llamada.

Por parte del Contratista de CRS, gracias por su paciencia y comprensión.

Si usted no está de acuerdo con el horario de nuestra extensión, usted puede presentar una queja. Usted puede comunicarse con nosotros al PONER NUMERO DE CONTACTO PARA QUEJAS ORAL o usted puede enviar su queja escrita a PONER DIRECCION.

Si usted necesita ayuda para presentar una queja, [inserte organizaciones de ayuda locales o legales.] Para más información sobre este aviso, usted puede comunicarse con la persona de quién el nombre y dirección aparece en la parte superior de este aviso. Usted también se puede referir al manual de los miembros para más información sobre el proceso de la autorización de servicios.

Sinceramente,

XXXXXXXXXXX
Nombre y credenciales
Titulo

Cc:
Proveedor Solicitante
Contratista de ALTCS/Acute Care

Section 11.3 Concurrent Review

A. Standards of Procedures

1. Children's Rehabilitative Services (CRS) Contractors shall have a system of utilization review for a member's hospital admission and hospital stay. The CRS Medical Director oversees this process.
2. CRS Contractors shall have procedures for review of medical necessity prior to a planned institutional admission (prior authorization) and for determination of the medical necessity for ongoing institutional care (concurrent review) using standard criteria (e.g. InterQuals' Level of Care Criteria).

B. Concurrent Review Staff

CRS Contractors shall have adequate, qualified, and professional medical staff (i.e., physician, physician assistant, nurse practitioner, and/or RN/BSN) to conduct reviews.

C. Concurrent Review Policies and Procedures

CRS Contractors' shall have policies and procedures that contain the following elements for the concurrent review process:

1. CRS Contractors shall have a process to ensure that the medical necessity review must include what relevant clinical information is to be obtained when making hospital length of stay decisions such as diagnosis, required services, diagnostic test results, and symptoms.
2. CRS Contractors shall ensure consistent application of review criteria and compatible decisions that include Inter-rater Reliability criterion and monitoring of all staff involved in the concurrent review process, including the CRS Medical Director.
3. CRS Contractors shall ensure that all previously (prior) authorized stays will have a specific date by which the need for continued stay would be reviewed.
4. Reviews of an admission not prior authorized will be conducted within one (1) business day after notification. The extension of a continued stay shall be assigned a new review date, not to exceed seventy-two (72) hours, each time a concurrent review occurs.
5. Decisions on coverage and medical necessity must be clearly documented.
6. CRS Contractors shall ensure that they have a process for review by another qualified physician in the event an ordering physician challenges a length of stay or level of care determination or decision of medical necessity.
7. CRS Contractors concurrent review staff shall have a process in place to communicate with the CRS Medical Director when a CRS member is found ineligible for a particular service or set of services.
8. CRS Contractor's utilization review staff shall coordinate with the hospital/facility's Utilization Review Department and Business Office regarding any change in authorization status.

9. All denials for continued services shall be signed by the CRS Medical Director.
10. Written notification of a denial of hospital days or services for a CRS member shall be sent to the CRS attending physician and all representative parties, including the insurance carrier, parent, or guardian, within twenty-four (24) hours prior to date of discontinued coverage.

All CRS Contractor concurrent review decisions are subject to retrospective review by Children's Rehabilitative Services Administration (CRSA).

Section 11.4 Decertification of a Hospital Stay

1. Children's Rehabilitative Services (CRS) Contractors shall have a system in place to manage CRS care and monitor the appropriateness of services. The CRS Medical Director oversees this process.
2. All elective and emergency hospital admissions are reviewed by the CRS Contractor's authorization department. If, during the course of hospitalization, the CRS member is determined by the concurrent review nurse to be potentially medically ineligible or is potentially ineligible for a particular service or set of services, the following will occur:
   a. CRS Contractor's utilization review nurse will review the pertinent; information/medical record with the CRS Medical Director or designee,
   b. If the CRS Medical Director makes the denial, the authorization status will reflect decertification of continued hospital days or services;,
   c. CRS Medical Director shall sign all denial, reduction, or modification of services decisions;.
   d. CRS Contractor's utilization review staff will coordinate with the contracting hospital's utilization review department and business office regarding any change in authorization status;
   e. Written notification of a denial of hospital days or services for a CRS member (decertification) shall be sent to the CRS attending physician and all responsible parties, including the insurance carrier and parent or guardian, within twenty-four (24) hours prior to the date of discontinued coverage; however, no notice of action shall be sent to the Arizona Health Care Cost Containment System (AHCCCS) members or families. Please refer to Contractor Policy and Procedure Manual Section 11.2, Notice of Action, Notice of Service Authorization Extension, and Notice to ALTCS/Acute Care Provider and Health Plan (only to be applied to eligible and enrolled Title XIX/XXI members) for appeals process.
   f. CRS Contractors will not be financially responsible for hospitalization or the physician component of care after the date of the denial.

Section 11.5 Retrospective Review

A. Standards of Procedures

Children's Rehabilitative Services (CRS) Contractors shall have a system for retrospective review including policies and procedures, coverage criteria, and processes for approval or denial of claims.

B. Retrospective Review Staff

1. CRS Contractors shall have qualified staff that includes an Arizona licensed nurse/nurse practitioner or physician, pharmacist or pharmacy technician with appropriate training to apply CRS medical criteria or make medical decisions. In addition, CRS Contractors shall have a system for maintaining files/documentation in a secured location.
2. CRS Contractors shall use a standardized criterion to make retrospective review decisions for medical necessity. Contractors must ensure consistent application of review criteria and compatible decisions that include Inter-Rater Reliability criteria and monitoring of staff involved in the retrospective review process, as well as a plan of action for staff who do not meet criteria and timelines.
3. CRS Contractor's retrospective review staff and CRS Medical Director must attend Inter-rater Reliability Testing at least annually and as requested by Children's Rehabilitative Services Administration (CRSA). CRS Contractor shall have a process for additional education, training, and monitoring of staff. New employees must attend the Inter-rater Reliability Testing within six (6) months of hire.

C. Emergency Services

CRS Contractors must complete retrospective reviews for all emergency services. A retrospective review form containing all the essential elements to determine medical necessity for the emergency service(s) shall be utilized.

D. Required Elements for Retrospective Review

1. Review must be conducted by qualified and professional medical staff,
2. A standard form will be used for the review,
3. Dates must be clearly specified to ensure timelines are met (e.g., date service was provided, date CRS was notified, and the date of the retrospective review),
4. Determination of the necessity of emergency room setting; Criteria for decisions on medical necessity must be clearly documented and based on reasonable medical evidence.
5. CRS eligible diagnosis was relevant to emergency services,
6. Services met the member's needs, and
7. Decisions on coverage and medical necessity are clearly documented.

E. Time frames for Retrospective Reviews

1. The time frames for retrospective reviews shall not exceed twenty-eight (28) days from date of receipt of notification.

2. All CRS Contractor prior authorization, concurrent, and retrospective decisions are subject to retrospective review by CRSA.

Section 11.6 Drug Utilization Patterns

A. Purpose

Drug utilization review (DUR) is a systematic, ongoing review of the prescribing, dispensing and use of medications. The purpose of drug utilization review is to assure the efficacious, clinically appropriate, safe, and cost-effective use of drug therapy to improve Children's Rehabilitative Services (CRS) members' health status and quality of care.

B. Polices and Procedures

1. CRS Contractors must develop and implement a system, including policies and procedures, coverage criteria, and review processes for their DUR programs.
2. Criteria for decisions on coverage and medical necessity must be clearly documented and based on the scientific evidence and standards of practice that include, but are not limited to, peer-reviewed medical literature, outcomes research data, official compendia, or published practice guidelines developed by an evidence-based process.
3. Provision for education of prescribers and CRS Contractor professionals on drug therapy problems based on utilization patterns with the aim of improving safety, prescribing practices, and therapeutic outcomes. The program must include a summary of the educational interventions used and an assessment of the effect of these educational interventions on the quality of care.

C. Drug Utilization Data Review

CRS Contractors must manage a Drug Utilization Review process that includes, but is not limited to:

1. All drugs before dispensing. This review process may be accomplished at the pharmacy using a computerized DUR system. The DUR system, at a minimum, must be able to identify potential adverse drug interactions, drug pregnancy conflicts, therapeutic duplication, and drug-age conflicts.
2. All non-formulary drug requests
3. Concurrent drug therapy of selected members to assure positive health outcomes
4. Retrospective drug utilization review process to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse. The review process serves as a means of identifying and developing prospective standards and targeted interventions

D. Pharmacy Data Analysis

CRS Contractor shall review pharmacy data periodically to detect changes or unusual patterns in drug utilization. Analysis may include pattern analyses that evaluate clinical appropriateness, over- and underutilization, identification of outliers, therapeutic duplication, drug-disease contraindication, drug-drug interaction, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products, and mail-order medications.

Section 11.7 Case Management/Care Coordination

A. Standards of Procedures

Children's Rehabilitative Services (CRS) Contractors must establish a process to ensure coordination of care for members that includes:

1. Coordination of CRS member health care needs through a Service Plan (See Contractor Policy and Procedure Manual Policy 11.14,
2. Collaboration with providers, communities, agencies, service systems, members, and families; and
3. Consultation reports sent to the referring physician and appropriate health plan within thirty (30) days of the first visit to include:
   i. Plan of care;
   ii. Diagnosis; and
   iii. Name, address, and phone number of the CRS provider.
4. CRS shall provide service coordination, communication, and support services designed to manage the transition of care for a member who requires temporary care within an alternative delivery system, or who no longer meets CRS eligibility requirements.
5. CRS Contractor must notify the Arizona Health Care Cost Containment System (AHCCCS) Contractor in writing sixty (60) days prior to the member's twenty-first birthday to ensure continuity of care. CRS is not financially responsible for an AHCCCS member on or after his/her twenty-first birthday. CRS Contractor must fill an AHCCCS Exhibit 520-2 (See AHCCCS Medical Policy Manual, Policy 520, Member Transitions) when transitioning a member who is turning 21 years of age.

B. Information Sharing

1. Information regarding CRS services shall be shared in a timely manner with all other appropriate professionals, with the member's or family's consent, through discharge planning activities, interdisciplinary team meetings, and service coordination activities.
2. CRS shall also notify an AHCCCS member's health plan/program contractor of the member's discharge when appropriate for care coordination.

Section 11.8 Adoption, Dissemination, and Implementation of Clinical Practice Guidelines

A. Annual Practice Guidelines Review

Children's Rehabilitative Services (CRS) Contractors shall provide input to the Children's Rehabilitative Services Administration (CRSA) Medical Director during the Clinical Practice Guidelines annual review and revision process.

B. Development of Dissemination Process

CRS Contractors must develop a process to ensure that CRSA clinical practice guidelines are disseminated to all affected providers and, upon request, to members and potential members.

C. Practice Guidelines Implementation

CRS Contractors must ensure the following:

1. Providers and clinic staff receive education regarding the specific practice guidelines and their desired outcomes.
2. Development and implementation of methodologies for monitoring provider compliance with the guidelines.
3. Implementation of actions designed to bring providers into compliance with the practice guidelines.

D. Monitoring Process

CRSA will monitor the CRS Contractor's processes for adoption, dissemination and implementation of CRSA Clinical Practice Guidelines during the annual administrative review.

E. Location of CRS Clinical Practice Guidelines

The CRS Clinical Practice Guidelines are located at http://www.azdhs.gov/phs/ocshcn/crs/crsa_clinical_practice_guidelines.htm.

Section 11.9 New Medical Technologies and New Uses of Existing Technologies

1. Children's Rehabilitative Services (CRS) Contractors may initiate a request for CRS coverage for new medical technologies and submit the proposal in writing to the Children's Rehabilitative Services Administration (CRSA) Medical Director for review. The proposal must include medical necessity criteria, supporting documentation, and a cost analysis for the new medical technology.
2. CRS Contractors shall participate in the review of new medical technologies and new uses of existing technologies through the CRSA/CRS Medical Directors Meeting.
3. CRSA shall review the requests and respond in a timely manner to the CRS Contractors on the decision for coverage by the CRS Program.
4. CRSA has ninety (90) days to make a determination regarding the new medical technology requested. If a determination is required prior to ninety (90) days due to an urgent need, CRSA will expedite the process to make determination within three (3) working days; with an extension option of an additional fourteen (14) calendar days. Expedited requests must be presented immediately to CRSA for a determination.

Section 11.10 Discharge Planning

A. Standards of Procedures

The Children's Rehabilitative Services (CRS) Contractor shall have policies and procedures that address discharge planning that include:

1. Inpatient discharge planning,
2. Pediatric to adult transition planning, and
3. Discharge planning for members aging out of the CRS system.

B. Inpatient Services

For CRS members receiving inpatient services, the CRS Contractor shall:

1. Initiate discharge planning upon the member's hospital admission,
2. Coordinate post hospital care with all responsible agencies, e.g., CRS, Department of Economic Security/Division of Developmental Disabilities (DES/DDD), Arizona Health Care Cost Containment System (AHCCCS), AHCCCS/Arizona Long Term Care Services (AHCCCS/ALTCS), DES/Comprehensive Medical and Dental Program (DES/CMDP), and DES Adoption Subsidy;
3. Decertify admissions for the CRS members in accordance with the Contractor Policy and Procedure Manual (CPPM) Section 11.4, Decertification of a Hospital Stay.

C. Transition of Members

1. For CRS members who are transitioning from pediatric to adult services, refer to CPPM Section 3.3, Transition of Care.
2. For CRS members aging out of the CRS system, refer to CPPM Section 3.3, Transition of Care.

Section 11.11 Specialty Referral Timeline

A. Standards of Procedures

The Children's Rehabilitative Services (CRS) Contractor shall have a policy and procedure that ensures adequate access to care through scheduling of appointments to specialists within forty-five (45) days of the date of a referral request. For urgent requests the timeframe for an appointment is seventy-two (72) hours.

B. Provider Listing

The CRS Contractor shall maintain and provide to Children's Rehabilitative Services Administration (CRSA) a detailed list of their providers and their specialties and will submit monthly reports of requests for referrals to specialists.

C. Failure to Provide CRS-Covered Services

If the Arizona Health Care Cost Containment System (AHCCCS) health plans are required to render any CRS-covered service due to the CRS Contractor's failure to meet medically necessary appointment standards, the CRS Contractor shall be financially responsible for those services.

D. Sanctions

The CRS Contractor shall be subject to sanction for failure to meet appointment standards.

Section 11.12 Telephonic Response Standards

The Children's Rehabilitative Services (CRS) Contractors shall have sufficient staff and policies and procedures to handle phone calls from members and applicants promptly and appropriately.

Section 11.13 Referral Management

The Children's Rehabilitative Services (CRS) Contractors will have a policy and procedure for referral of members for specialized care. Examples of referrals include: out-of-state referrals, second opinions, referrals from one CRS clinic specialist to another, health plan referrals, and referrals from primary care providers to CRS clinics.

Section 11.14 Service Plan

A. Introduction

The Service Plan (SP) shall serve as a working and guiding document for integrating the multiple treatment plans into language that the Children's Rehabilitative Service (CRS) member or family can understand. The SP shall identify desired outcomes, resources, priorities, concerns, and strategies to meet identified goals.

B. CRS Contractor's Service Plan

1. The CRS Contractor shall initiate a SP for each member at the time of enrollment. The SP shall identify the immediate healthcare needs of each newly enrolled member with an action plan. The comprehensive SP must be developed within ninety (90) calendar days from date of enrollment and contain all the required elements.
2. The CRS Contractor shall develop a comprehensive SP for members enrolled prior to October 1, 2008, at the time of their next re-determination as required in accordance with Section 4.7, Re-determination of Member Payment Responsibility.
3. The CRS Contractor shall modify and update the SP when there is a change in the member's condition or recommended services. This shall occur periodically as determined by the member, family, or provider.

C. Implementation of Service Plan

The CRS Contractor shall identify a care coordinator responsible for ensuring implementation of interventions and the dates by which the interventions must occur and shall identify specific agencies or organizations with which treatment must be coordinated.

D. Service Plan Required Elements

The SP required elements consist of the following:

1. Member demographics and enrollment data;
2. CRS covered medical diagnoses, past treatment, previous surgeries (if any), medications, and allergies;
3. The member's current status, including present levels of function in physical, cognitive, social, and educational domains;
4. The member's or family's barriers to treatment, such as member's or family's ability to travel to an appointment;
5. The member or family's strengths, resources, priorities, and concerns related to achieving mutual recommendations and caring for the family or the child;
6. Services recommended to achieve the identified objectives, including provider or person responsible and timeframe requirements for meeting desired outcomes; and
7. The CRS Contractor must identify an interdisciplinary team, including but not limited to, care coordinator, social worker, registered nurse (RN), a physician, and PCP to develop, implement, and update the SP as needed.

Section 12.1 Policies and Procedures and Requirements for Delegated Activities

1. The Children's Rehabilitative Services Administration (CRSA) must oversee and be accountable for the Quality Management/Performance Improvement (QM/PI) program; however, the Children's Rehabilitative Services (CRS) Contractors must oversee and be accountable for any activities that are delegated to outside entities.
2. The CRS Contractors shall have policies and procedures that emphasize quality in all aspects of providing services to the CRS population. This requirement includes processes within the clinic setting as well as processes for monitoring other provider services outside of the clinic setting.
3. Delegation of any activities to another entity does not alleviate the CRS Contractor's responsibility for ensuring quality. Documentation must be kept on file, and available to CRSA upon request, that shows the following requirements have been met for the delegated functions:
    a. A written agreement specifying the delegated activities and reporting responsibilities of the entity that provides for revocation of the delegation or other remedies for inadequate performance,
    b. An evaluation by the CRS Contractor of the entity's ability to perform the activities prior to delegation,
    c. Ongoing monitoring of the performance and quality of services provided and a formal review at least annually, and
    d. Written evaluations and corrective action plans (CAP), as necessary.

Section 12.2 Quality of Care Issues

A. Quality of Care Allegations

1. The Children's Rehabilitative Services (CRS) Contractor is responsible for investigating all quality of care allegations involving its own clinic activities as well as other services provided directly or through provider sub-contracts, regardless of the source of the allegation. Quality of care issues identified through the grievance or appeal processes are subject to the requirements below in Section 12.2 (D), (E), and (F).
2. Substantiated allegations must be resolved on both individual case and system levels.

B. Quality of Care Files

The CRS Contractor shall maintain Quality of Care files on each case that shall contain detailed documentation of the research, actions, and outcomes. The files shall be available to Children's Rehabilitative Services Administration (CRSA) on request.

C. Notification to CRSA

In addition to the requirements to notify CRSA when quality of care issues are identified through grievances and appeals, CRSA also shall be notified immediately of all quality of care issues with an initial severity level of 2 or above, as defined at the end of this chapter, when the CRS Contractor identifies an issue through its own internal processes or through audits and reviews by outside agencies or consultants.

D. Reviewing, Evaluating, and Resolving Quality of Care Issues

1. The CRS Contractor shall have written policies and procedures for reviewing, evaluating, and resolving quality of care issues regardless of who within the organization receives the grievances that include:
    a. Making a prompt determination of whether a grievance is a non-quality of care concern or a quality of care concern and assigning a severity level (Severity levels are defined at the back of this section. Zero equals non-quality of care and one and above equal quality of care issues.),
    b. Identifying how the CRS Medical Director is informed of quality of care issues, is involved in the assignment of severity levels, and oversees interventions and final resolutions,
    c. Immediately reporting initial severity level 2, 3, 4 to CRSA's Division of Quality Management,
    d. Determining Quality of Care Categories (See Attachments 3 and 4),
        i. main category and
        ii. subcategory,
    e. Immediately reporting to CRSA closing severity level when higher than initial severity level,
    f. Acknowledging receipt of the concern and explaining to the member or provider the process to be followed in resolving his or her concern through written correspondence. A Quality of Care Acknowledgement letter template (Attachment 1) is for use under the CRS Contractors own letterhead and with the name, title, credentials, and telephone number of the person sending the letter.

g. Documenting all processes (include detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each grievance determined to be a quality of care issue on both an individual and system level, including but not limited to interventions, including the provision of immediate medical needs as approved by the CRS Medical Director.

h. Follow-up with the member that includes, but is not limited to:

i. Assistance as needed to ensure that the immediate health care needs of the member are met; and

ii. A Quality of Care Resolution Letter (Attachment 2) on the CRS Contractor's letterhead is sent. The letter shall provide sufficient details to ensure all covered, medically necessary health care needs are met; contact name/title, and telephone number to call for assistance or to express any unresolved concerns; the name, title and credentials of the person signing the letter; and if applicable, the Member's Arizona Health Care Cost Containment System (AHCCCS) ID number.

i. Documenting closure of the review.

2. Additional actions by the CRS Contractors may be necessary, based on individual case circumstances, before a case is closed. These actions may include:

a. Referring/reporting the issue to appropriate regulatory agencies such as Child or Adult Protective Services, AHCCCS, and/or CRSA for further research/review or action,

b. Notifying the appropriate regulatory/licensing board or agency and CRSA when a health care professional's, organizational provider's or other provider's affiliation with their network is suspended or terminated because of quality of care issues, and

c. Referral to the CRSA Peer Review Committee.

E. Tracking and Trending

The CRS Contractor is responsible for tracking Quality of Care issues. Procedures for tracking and trending shall include:

1. Contractors must ensure that member health records, as well as the records described in Contractor Policy and Procedure Manual Section 8.1 are available and accessible to authorized staff or their organization and to appropriate State and Federal authorities, or their delegates, involved in assessing quality of care issues.
2. The CRS Contractor shall log and track all quality of care issues.
3. The quality of care issues tracking log must be completed using CRSA specified forms and/or databases.
4. The logs and/or databases must be submitted to CRSA by the 15th of the month for the preceding month.

Attachment 1

Quality of care acknowledgment letter

(On Contractor letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.

XXX-XXX-XXXX or (800) XXX-XXXX

Date

(*Name of person filing the grievance)*
Address
City, State, Zip

RE: *(CRS Member # & AHCCCS* # if *applicable)*

Dear *(Name)*:

(Phoenix, Tucson, Flagstaff, Yuma) Children's Rehabilitation Services at the (Phoenix, Tucson, Flagstaff, Yuma address), has received your concerns related to care you have been requesting for your son/daughter through CRS.

(Phoenix, Tucson, Flagstaff, Yuma) CRS clinic will research and respond to this issue. Be assured this issue will be given full consideration. A written response will be sent when the research into this issue has been completed.

This information will be kept confidential under 42 C.F.R. § 434.34, A.R.S. § 8-546.11(C)(11), A.R.S. § 36-2401, et seq., A.R.S. § 36-445, and A.R.S. § 41-1959C(5).

Thank you for contacting CRS regarding this issue. The quality of health care of all of our members is important to us. You can contact XXXXXXXXX, Quality Management Manager at (XXX) XXX-XXXX if you have any questions regarding this issue.

Sincerely,

*Name and credentials*XXXXXXXXXX
Title

Attachment 2

Quality of care resolution letter

(On Contractor letterhead)

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will assist you.

Si usted tiene dificultades leyendo este aviso porque las letras son demasiado pequeñas o las palabras son muy dificil para leer, favor de llamarnos al xxxxxx y alguien le asistirá.

XXX-XXX-XXXX or (800) XXX-XXXX

Date

(Name of person filing the grievance
Address
City, State, Zip)

RE: *(CRS Member # & AHCCCS* # if *applicable)*

Dear *(Name)*:

(Phoenix, Tucson, Flagstaff, Yuma) Children's Rehabilitation Services has completed its review related to XXXXXXXXXXXXXXXXXX.

Provide explanation in lay person's terms

This information will be kept confidential under 42 C.F.R. § 434.34, A.R.S. § 8-546.11(C)(11), A.R.S. § 36-2401, et seq., A.R.S. § 36-445, and A.R.S. § 41-1959C(5).

Thank you for contacting CRS regarding this issue. The quality of health care of all of our members is important to us. You can contact XXXXXX, at (XXX) XXX-XXXX if you have any questions regarding this issue.

Sincerely,

Name and credentials
Title

Attachment 3

QUALITY OF CARE CONCERN SEVERITY LEVELS

Level 0- Track only:

No risk for it to be a quality of care concern, risk of harm, permanent damage, increased cost of care, lengthened stay, permanent damage, or potential media event. Concerns may be related to physical elements of the clinic and discourtesy.

Level 1- Concern that MAY impact the member if not resolved:
Potential unsafe home environment; non-compliance with appointment scheduling or wait time requirements; need for information or referral to resolve an issue.

Level 2- Concern that WILL impact the member if not resolved:

Including slow, or no responsiveness to a request for evaluation, treatment other request; member rights violation; inadequate case management; physician clinic cancellations; availability/timeliness of transportation for medical appointments.

Level 3- Concern that IMMEDIATELY impacts the member and is considered life threatening or dangerous

Including situations of immediate jeopardy to the member; abuse and neglect; inadequate or inappropriate care of an acute condition; denial of services deemed medically necessary by the member/provider; potential provider misconduct; issues with, or the potential for, adverse media coverage or the potential for a lawsuit; and issues referred by the AHCCCS Director's Office.

Level 4- Concern that no longer impacts the member but may have potential to be life threatening or dangerous to other members:

Unexpected death has resulted, directly or indirectly as a result of care given or omitted. Media coverage assured. Lawsuit filed or in process.
Examples include cases abuse and neglect; unexpected deaths; and cases from the Governor's Office, Legislature, or ADHS Director/Assistant Director's Office regardless of the nature.

Attachment 4

Quality of Care Categories

MAIN CATEGORY	SUB-CATEGORY
Availability, Accessibility & Adequacy (AAA)	Specialty selection
Availability, Accessibility & Adequacy (AAA)	Specialty change
Availability, Accessibility & Adequacy (AAA)	Access to services
Availability, Accessibility & Adequacy (AAA)	Access to specialists
Availability, Accessibility & Adequacy (AAA)	Adequacy of provider network
Availability, Accessibility & Adequacy (AAA)	Appointment availability
Availability, Accessibility & Adequacy (AAA)	Delay in referral
Availability, Accessibility & Adequacy (AAA)	Delay in treatment/service
Availability, Accessibility & Adequacy (AAA)	Provider refusal to provide care
Availability, Accessibility & Adequacy (AAA)	Telephone access
Availability, Accessibility & Adequacy (AAA)	Transportation
Availability, Accessibility & Adequacy (AAA)	DME
Availability, Accessibility & Adequacy (AAA)	Environmental Modifications
Availability, Accessibility & Adequacy (AAA)	Other
Effectiveness/Appropriateness of Care	Inappropriate treatment
Effectiveness/Appropriateness of Care	Treatment is ineffective or below medical standards
Effectiveness/Appropriateness of Care	Non-formulary medications
Effectiveness/Appropriateness of Care	Missed diagnosis
Effectiveness/Appropriateness of Care	Dietary services inappropriate
Effectiveness/Appropriateness of Care	Skin integrity
Effectiveness/Appropriateness of Care	Access to medical care
Effectiveness/Appropriateness of Care	Delay in providing medical records or treatment plan to PCP
Effectiveness/Appropriateness of Care	Inappropriate transfer
Effectiveness/Appropriateness of Care	Inappropriate discharge
Effectiveness/Appropriateness of Care	Other
Safety/Risk Management	Pharmacy Prescription error
Safety/Risk Management	Injury/accident

Safety/Risk Management	Unsafe environment
Safety/Risk Management	Poor operation or conditions (DME)
Safety/Risk Management	Documentation/medical record
Safety/Risk Management	Altered medical records
Safety/Risk Management	Discharge AMA
Safety/Risk Management	Receipt of services AMA
Safety/Risk Management	Unexpected death
Safety/Risk Management	Other
Member Rights/Respect and Caring	Continuity of caring
Member Rights/Respect and Caring	Coordination of care
Member Rights/Respect and Caring	Advance directives
Member Rights/Respect and Caring	Disrespectful/unprofessional conduct by provider
Member Rights/Respect and Caring	Disrespectful/inappropriate conduct by member
Member Rights/Respect and Caring	Not including member/parent in plan of care
Member Rights/Respect and Caring	Member dissatisfaction with treatment plan or care provided
Member Rights/Respect and Caring	Physical abuse
Member Rights/Respect and Caring	Physical neglect
Member Rights/Respect and Caring	Emotional abuse
Member Rights/Respect and Caring	Culturally insensitive
Member Rights/Respect and Caring	Restraints-physical
Member Rights/Respect and Caring	Restraints-chemical
Member Rights/Respect and Caring	Denial letter(s) not provided
Member Rights/Respect and Caring	Reduction in service letter(s) not provided
Member Rights/Respect and Caring	No access to medical records
Member Rights/Respect and Caring	No grievance process information provided
Member Rights/Respect and Caring	Other
Denial, Decrease or Discontinuance of Covered	Denial of services- not medically necessary
Denial, Decrease or Discontinuance of Covered	Denial of services- no prior authorization
Denial, Decrease or Discontinuance of Covered	Denial of services-not a covered service
Denial, Decrease or Discontinuance of Covered	Denial of services-eligibility
Denial, Decrease or Discontinuance of Covered	Denial of services payer of last resort
Denial, Decrease or Discontinuance of Covered	Decrease in the amount of service previously provided
Denial, Decrease or Discontinuance of Covered	Discontinuance of service provided
Denial, Decrease or Discontinuance of Covered	Discontinuance of previously covered benefit
Denial, Decrease or Discontinuance of Covered	Other
Fraud (i.e., by a member, a provider, or	Referrals to entities in which the provider or family member

financial)	has a financial interest
Fraud (i.e., by a member, a provider, or financial)	Inappropriate billing
Fraud (i.e., by a member, a provider, or financial)	Inappropriate use of covered benefit
Fraud (i.e., by a member, a provider, or financial)	Use of service by someone other than an enrolled member
Fraud (i.e., by a member, a provider, or financial)	Altered medical record due to fraudulent action

Section 12.3 Credentialing and Re-credentialing Processes

A. Introduction

This policy covers credentialing, temporary/provisional credentialing, and re-credentialing policies for both individual and organizational providers. Accreditation of the Children's Rehabilitative Services (CRS) Contractor, specific to its line of business serving the Arizona Health Care Cost Containment System (AHCCCS) and CRS State-Only members, by the National Committee for Quality Assurance (NCQA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will demonstrate that credentialing and re-credentialing requirements have been met.

B. Credentialing and Re-credentialing Providers

The CRS Contractor must have a system supported by written policies and procedures or bylaws for credentialing and re-credentialing providers included in the contracted provider network that meet Children's Rehabilitative Services Administration (CRSA) and AHCCCS requirements.

1. Credentialing and re-credentialing must be conducted and documented for at least the following contracted health care professionals:
   a. Physicians (MDs, DOs and DPMs),
   b. Nurse practitioners, physician assistants, or certified nurse midwives providing primary care services, including prenatal and delivery services,
   c. Dentists,
   d. Psychologists, and
   e. Other certified behavioral health professionals who contract directly with the CRS Contractor.
2. The CRS Contractor must ensure:
   a. The credentialing and re-credentialing processes do not discriminate against:
      i. A health care professional, solely on the basis of license or certification, or
      ii. A health care professional who serves high-risk populations or who specializes in the treatment of costly conditions.
   b. Compliance with Federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid.
3. ADHS/CRS delegates the credentialing and re-credentialing process to CRS Contractors, however, ADHS/CRS has the right to approve, suspend, or terminate any providers selected by the Contractor. If the CRS Contractor delegates to another entity any of the responsibilities of credentialing/re-credentialing or selection of providers that are required by Section 12.3, Credentialing and Re-credentialing Processes, it must retain the right to approve, suspend, or terminate any provider selected by that entity and must meet the requirements for delegation in Section, 12.1, Policies and Procedures and Requirements for Delegated Activities. The CRS Contractor remains responsible for delegated credentialing or

re-credentialing decisions and shall maintain a credentialing committee in which the CRS Medical Director has final authority for CRS credentialing decisions. CRSA will maintain oversight responsibilities over the CRS Contractor Medical Director's CRS credentialing decisions.

4. Written policies must reflect the scope, criteria, timeliness, and process for credentialing and re-credentialing providers. The policies and procedures must be reviewed and approved by the CRS Contractor's executive management and:
   a. Reflect the direct responsibility of the CRS Medical Director or other designated physician for the oversight of the process and delineate the role of the credentialing committee,
   b. Indicate the utilization of participating providers in making credentialing decisions, and
   c. Describe the methodology to be used by CRS Contractor staff and the CRS Contractor Medical Director to provide documentation that each credentialing or re-credentialing file was completed and reviewed, as per Section 12.3 (B)(1) above, prior to presentation to the credentialing committee for evaluation.
5. CRS Contractors must maintain an individual credentialing/re-credentialing file for each credentialed provider. Each file must include:
   a. The initial credentialing and all subsequent re-credentialing applications,
   b. Information gained through credentialing and re-credentialing queries, and
   c. Any other pertinent information used in determining whether the provider met the CRS Contractor's credentialing and re-credentialing standards.

C. Initial Credentialing

At a minimum, policies and procedures for the initial credentialing of physicians and other licensed health care providers must include:

1. A written application to be completed, signed, and dated by the provider that attests to the following elements:
   a. Reasons for any inability to perform the essential functions of the position, with or without accommodation,
   b. Lack of present illegal drug use,
   c. History of loss of license and/or felony convictions,
   d. History of loss or limitation of privileges or disciplinary action,
   e. Current malpractice insurance coverage, and
   f. Attestation by the applicant of the correctness and completeness of the application.
2. Minimum five (5) years work history
3. Drug Enforcement Administration (DEA) or Chemical Database Service (CDS) certification
4. Verification from primary sources of:
   a. Licensure or certification,
   b. Board certification, if applicable, or highest level of credentials attained,
   c. Documentation of graduation from an accredited school and

completion of any required internships/residency programs, or other postgraduate training, if the CRS Contractor lists physician schooling information in member materials or on their Web site, and/or

d. National Provider Databank (NPDB) query or, in lieu of the NPDB query, all of the following must be verified:
   i. Minimum five (5) years history of professional liability claims resulting in a judgment or settlement, and
   ii. Disciplinary status with regulatory board or agency, and
   iii. Medicare/Medicaid sanctions, and
   iv. State sanction or limitations of licensure.

5. The CRS Contractor must conduct timely verification of information, as evidenced by notification of provider of approval status within one hundred eighty (180) days of receipt of complete application. The CRS Contractor must also enter all required information in to the CRS Contractorôs information system to allow timely claim processing.

D. Temporary/Provisional Credentialing

1. Contractors must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process.
2. Temporary or provisional credentialing is intended to increase the available network of providers in medically underserved areas, whether rural or urban. The CRS Contractor must follow the ñInitial Credentialingò guidelines Section 12.3 (C)(1-4) when granting temporary or provisional credentialing. The CRS Contractor shall have fourteen (14) days from receipt of a complete application, accompanied by the minimum documents identified above, within which to render a decision regarding temporary or provisional credentialing.
3. The CRS Contractor must follow the ñInitial Credentialingò guidelines Section 12.3 (C)(1-4) above to complete the credentialing process following the granting of temporary or provisional credentials.
4. For consideration of temporary or provisional credentialing, at a minimum, a provider must complete a signed application that must include the following items:
   a. Reasons for any inability to perform the essential functions of the position, with or without accommodation,
   b. Lack of present illegal drug use,
   c. History of loss of license and/or felony convictions,
   d. History of loss or limitation of privileges or disciplinary action,
   e. Current malpractice insurance coverage, and
   f. Attestation by the applicant of the correctness and completeness of the application.

   In addition, the applicant must furnish the following information:
   a. Work history for past five (5) years and
   b. Current DEA or CDS certificate.

   The CRS Contractor must conduct primary verification of the following:
   a. Licensure or certification,

b. Board certification, if applicable, or the highest level of credential attained, and

5. National Provider Data Bank (NPDB) query or in lieu of the NPDB query, all of the following:
   a. Minimum five (5) years history of professional liability claims resulting in a judgment or settlement, and
   b. Disciplinary status with regulatory board or agency, and
   c. Medicare/Medicaid sanctions.
6. The CRS Contractor Medical Director must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification and committee review, as outlined in this Section 12.3, should be completed.
7. The CRS Contractor must conduct timely verification of information, as evidenced by notification of provider of approval status within one hundred eighty (180) days of receipt of complete application. The CRS Contractor must also enter all required information in to the CRS Contractor's information system to allow timely claim processing.

E. Re-credentialing Providers

At a minimum, the re-credentialing policies for physicians and other licensed health care providers must identify procedures that address the re-credentialing process and include requirements for:

1. Re-credentialing at least every three (3) years,
2. An update of information obtained during the Initial Credentialing for Section 12.3 (C)(1) (except (1)(c)), (3) and (4) ((4)(b) only requires update if provider is board certified), and
3. A process for ongoing monitoring and intervention, if appropriate, of provider sanctions, complaints, and quality issues pertaining to the provider, which must include, at a minimum, review of:
   a. Medicare/Medicaid sanctions,
   b. State sanctions or limitations on licensure,
   c. Member concerns which include grievances (complaints) and appeals information,
   d. CRS Contractor Quality issues,
   e. Utilization management information (such as emergency room utilization, hospital length of stay, pharmacy utilization),
   f. Performance improvement and monitoring (performance measure rates), and
   g. Results of medical record review audits.

F. Credentialing Organizational Providers

For organizational providers included in the CRS Contractor's network (including hospitals, home health agencies, and free-standing surgi-centers):

Each CRS Contractor must validate and re-validate at least annually that the organizational provider:

1. Is licensed to operate in the State of Arizona, and is in compliance with any other applicable State or Federal requirements, and
2. Is reviewed and approved by an appropriate accrediting body or, if not

accredited, Centers for Medicare and Medicaid Services (CMS) certification or State licensure review may substitute for accreditation. In this case, the Contractor must maintain documentation of the following:

a. Review by Arizona Department of Health Services (ADHS);
b. Summary of ADHS findings including date of their review;
c. Contractor conducted on-site inspection to verify compliance with ADA requirements.

3. Is monitored by the Contractor with standards developed by the Contractor to assure the provider is meeting AHCCCS requirements as well as Contractor/provider contractual agreements.
4. Is reviewed and approved by the Contractor's credentialing committee with formal documentation that includes any discussion, review of thresholds, and complaints of grievances.
5. Each Contractor must monitor organizational provider specific information including, but not limited to:
   a. Member concerns which include grievances (complaints);
   b. Utilization management information (if applicable);
   c. Performance improvement and monitoring (if applicable);
   d. Results of medical records review audits (if applicable);
   e. Quality of care issues and trends; and
   f. Onsite assessments.

G. CRSA Notification Requirement

The CRS Contractor must report to the CRSA Medical Director, who shall bring before the CRSA Peer Review Committee, upon discovery, any known serious issue and/or quality deficiency that could affect quality of care provided to CRS members.

Section 12.4 Peer Review

A. Purpose

The purpose of the peer review process is to improve the quality of medical care provided to members by providers through a fair and impartial investigative process.

B. Requirements

1. The CRS Contractor must participate in the CRSA Peer Review Committee.
2. The Contractor must also convene a Peer Review Committee, which must be chaired by the Contractor's Medical Director.
3. The Contractor shall not delegate the peer review process to other entities.

C. CRS Contractor Peer Review Committee

Peer review policies and procedures and requirements for the Contractor's peer review committee must include the following:

1. Peer review committee meetings shall minimally be scheduled quarterly. The committee may meet within an executive session during the quarterly quality management committee meetings or as a separate meeting.
2. The peer review committee chair may delay review if the delay is determined to be in the best interest of the review process. Delays are not to exceed forty-five (45) calendar days unless exceptional circumstances arise. Examples permissible of a delay include:
    a. the next scheduled peer review committee meeting is too soon to prepare for the review,
    b. absence of persons essential to the process,
    c. exceptional circumstances (e.g.., awaiting autopsy reports).
3. At a minimum, the peer review committee shall consist of the CRS Contractor's Medical Director and CRS contracted providers from the community.
4. The peer review process must ensure that providers of the same or similar specialty participate in review and recommendation of individual peer review cases. The Contractor may utilize peers of the same or similar specialty through external consultation should that specialty not be represented on the Contractor's peer review committee.
5. The peer review committee must evaluate the case referred to peer review based on all information made available through the quality management process.
6. The peer review committee is responsible for making recommendations for action to the Contractor's Medical Director that may include but, is not limited to, peer contract, education, credentials, caps on provider enrollment, sanctions, or other corrective actions.
7. The peer review process may also include recommendations for the Contractor's Medical Director to make referrals to regulatory and licensure agencies such as child or adult protective services, the Arizona Health Care Cost Containment System Administration (AHCCCSA), CRSA, and the National Provider Data Bank (NPDB) for further investigation if the peer review committee determines that care was not provided according to community standards.
8. Confidentiality
    a. CRS Contractor peer review policies and procedures must assure that all information used in the peer review process shall be kept confidential and

not be discussed outside of the peer review process. The CRS Contractorôs peer review reports, meetings, minutes, documents, recommendations, and participants shall be kept confidential except for purposes of implementing recommendations made by the peer review committee.

b. Peer review committee members shall sign a confidentiality and conflict of interest statement at each peer review committee meeting. Committee members may not participate in peer review activities in which they have a direct or indirect interest in the outcome.

9. Sharing Outcomes
   a. CRS Contractors must make peer review outcomes available to CRSA within ten (10) business days of a peer review outcome, corrective action, or decision for purposes of quality management, monitoring and oversight.
   b. CRS Contractor peer review outcome reports should include the following:
      i. date of the peer review committee meeting,
      ii. name, title, and specialty of committee members and external reviewers conducting the peer review,
      iii. providerôs CRSA identification number and specialty,
      iv. brief description of incident under review,
      v. findings of fact and conclusions of law, and
      vi. outcomes, corrective actions, and decisions.
10. Contractors must demonstrate how the review process is used to analyze and address clinical issues.
11. Contractors must demonstrate how providers are made aware of the peer review process.
12. Contractors must demonstrate how providers are made aware of the peer review grievance procedure, and

Section 12.5 Performance Measures

A. Introduction

All Performance Standards described below apply to all members. Contractors must show demonstrable and sustained improvement toward meeting Performance Standards established by the Arizona Department of Health Services (ADHS)/Children's Rehabilitative Services Administration (CRSA) and at least meet stated Minimum Performance Standards.

1. ADHS/CRSA has established two levels of performance:
   a. Minimum Performance Standard – A Minimum Performance Standard is the minimally expected level of performance by the Children's Rehabilitative Services (CRS) Contractor. If the CRS Contractor does not achieve this standard or the rate for any indicator declines to a level below the ADHS/CRSA Minimum Performance Standard, the CRS Contractor will be required to submit a corrective action plan (CAP) and may be subject to sanctions.
   b. Goal – The Goal is the ultimate benchmark to be achieved. If the CRS Contractor has already achieved or exceeded the Minimum Performance Standard for any performance measure, the CRS Contractor must strive to meet the goal for that measure. If the CRS Contractor has achieved the Goal, the CRS Contractor is expected to maintain or improve this level of performance in future years.

2. The following table identifies the Minimum Performance Standards and Goals for each Measure:

   CRS PERFORMANCE MEASURES

Performance Measure	Minimum Performance Standard	Goal
Eligibility Determination	75%	90%
First Appointment with CRS Specialty Provider	75%	90%

3. The CRS Performance Measures are defined as follows:
   a. Eligibility Determination: The percent of applicants who were notified in writing of their eligibility status within fourteen (14) calendar days of a CRS Referral Form received by the CRS Regional Contractor*. Eligibility determination categories include: eligible, ineligible, incomplete referral, and initial medical evaluation needed.

      * A complete CRS Referral Form is one that includes information in all the required fields to be submitted on the form, as specified in the CRS Contractors Policy and Procedure Manual (CPPM), 4.2, Referrals.

b. Timeliness of First Appointment with CRS Specialty Provider ï The percent of members who are enrolled in CRS and are scheduled for their first specialty clinic visit within forty-five (45) calendar days of the CRS Contractor making a positive determination of medical eligibility, or within the timelines outlined in the memberôs service plan.

4. The CRS Contractor shall submit New Member Reports monthly to CRSA per Appendix F to document the above.

5. CRS Contractors must develop a Corrective Action Plan (CAP) for each measure not meeting minimum performance standards to bring performance up to at least the minimum level established by ADHS/CRSA and AHCCCS. Each CAP should utilize a Plan-Do-Study-Act (PDSA) cycle as described below.

   The PDSA cycle consists of the following steps:
   a. Plan. Plan the change(s) or intervention(s), including a plan for collecting data. State the objective(s) of the intervention(s).
   b. Do. Try out the intervention(s) and document any problems or unexpected results.
   c. Study. Analyze the data and study the results. Compare the data to predictions and summarize what was learned.
   d. Act. Refine the change(s)/intervention(s), based on what was learned, and prepare a plan for retesting the intervention(s).
   e. Repeat. Continue the cycle as new data becomes available until improvement is achieved.

6. CRS Contractors must submit all action plans ADHS/CRSA for approval prior to implementation. Each CAP must include the following components:
   a. Document the results of an evaluation of existing interventions to achieve performance standards, including barriers to utilization of services and/or reasons why the interventions have not achieved the desired effect (*plan*),
   b. Identify new or enhanced interventions that will be implemented in order to bring performance up to at least the minimum performance standard, including evidence-based practices that have been shown to be effective in the same/similar populations (*plan*),
   c. Demonstrate that the Contractor is allocating increased administrative resources to improving rates for a particular measure or service area (*do*),
   d. Identify staff positions responsible for implementing/overseeing interventions with specific timeframes for implementation (*do*),
   e. Provide a means for measuring the results of new/enhanced interventions on a frequent basis (*study*),
   f. Provide a means for refining interventions based on what is learned from testing different approaches or activities (*act*), and
   g. Describe a process for repeating the cycle until the desired effectð a rate that meets or exceeds the minimum performance standards listed aboveð is achieved.

Section 12.6 Quality Management (QM) Data Validation

A. Introduction

Children's Rehabilitative Services Administration (CRSA) will ensure that information and data received from Contractor(s) is accurate, timely and complete by reviewing and evaluating the reported data for accuracy, completeness, logic, and consistency.

B. Standard

Contractor(s) shall have written policies and procedures to ensure that (AHCCCS AM/PM Chapter 910-8):

1. Information/data received from providers is accurate, timely and complete.
2. Reported data is reviewed for accuracy, completeness, logic and consistency, and the review and evaluation processes used are clearly documented.
3. All member and provider information protected by Federal and State law, regulations, or policies is kept confidential, and
4. Contractor staff and providers are kept informed of at least the following:
    - i) QM/PI requirements, activities, updates or revisions,
    - ii) Study and PIP results,
    - iii) Performance measures, and
    - iv) Provider Profiling results.

C. Data Submission Procedures

1. Before submitting CRSA data deliverables, the Contractor(s) shall :
    - a. Perform checks for missing data,
    - b. Perform logic and range checks,
    - c. Verify correct data formats in fields (For example, text in text fields or correct date formats in date fields),
    - d. Checks for duplicate observations, and
    - e. Review changes from the previous to current submission.
2. Contractor(s) shall ensure that data error rates do not exceed 10% for data submissions.
3. If the error rate is above the standard set by CRSA, the Contractor is required to resubmit corrected data.
    - a. Resubmission timeframe is within 5 business days
    - b. Data resubmissions must be sent to the Compliance Division of CRSA.
4. Contractor(s) shall review error reports within a committee structure on a quarterly basis.
5. Contractor(s) shall take and document immediate correction action when error rates exceed the CRSA minimum standard.

D. Inter-Rate Reliability

On an annual basis, or as needed, the Contractor staff who place data in the Quality of Care database will participate in inter-rater reliability testing. Contractors may receive technical assistance from ADHS if needed.

Section 13.1 CRS Contractor Employee Training Requirements

A. Introduction

CRS Contractor employees must participate in appropriate training and educational opportunities within ninety (90) days of their start date in order to effectively meet the requirements of the ADHS/CRSA service delivery system. ADHS/CRSA requires that CRS Contractor staff and providers receive specific training with the intended purpose of meeting the following goals:

1. To promote a consistent family-centered practice philosophy;
2. To assist CRS Contractors in developing a qualified, knowledgeable, and culturally competent workforce; and
3. To ensure that services are delivered with the family-centered philosophy that reflects the vision and mission of the CRS Program.

B. General Orientation and Annual Training Requirements

1. At a minimum, the additional following content areas should be covered in CRS Contractor's new employee orientation:
   a. CRS Program Overview;
   b. Grievances and Appeals processes;
   c. Quality of Care process;
   d. Notice of Action;
   e. Transition Planning;
   f. Member Rights; and
   g. Coordination of Care.

2. At a minimum, the following content areas must be covered in new employee orientation and annually thereafter:
   a. Cultural Competency, which should include:
      i. Culturally and Linguistically Appropriate Services (CLAS) Standards;
      ii. Cultural Competency terms;
      iii. Principles of family-centered care;
      iv. Use of interpretation and language assistance services;
      v. Limited English Proficiency (LEP);
      vi. TDD/TTY and other Americans with Disabilities Act (ADA) accommodations;
      vii. Grievances and provisions of culturally appropriate care; and
      viii. Creating awareness concerning children and their families health related benefits, attitudes, values, and behaviors and incorporating them into practice.
   b. Corporate Compliance (Fraud and Program Abuse), which should cover content area detailed in Section 80.800; and
   c. Business Continuity and Recovery Plan.

C. Required Training Specific to Provider Service Representatives

The following content areas must also be included in the orientation and training program for provider service representatives or any personnel responsible for providing policy and procedure clarifications and assistance to providers:

1. Claims processing;
2. Prior-authorizations; and
3. Claim disputes process.

D. CRSA's Learning Management System (LMS)

ADHS/CRSA provides many trainings through the LMS, an e-learning environment. To participate in trainings via LMS, participants must first register to receive access to LMS by contacting the E-Learning Program Manager at CRSA at (602) 542-1860.

E. CRSA Training Catalog and Training Requests

ADHS/CRSA will maintain a catalog of trainings available to contractor staff and their providers. The trainings will be available through the Learning Management System (LMS), face to face, and/or video conference. The training catalog is available on the ADHS/CRSA web page. Trainings included in the catalog are:

1. Cultural Competency;
2. Fraud and program abuse;
3. Grievance and Appeals processes;
4. Quality of Care process;
5. Notice of Action;
6. Business Continuity and Recovery Plan;
7. Transition Planning;
8. Member Rights, and
9. Coordination of Care.

CRSA will assess the need for other training topics on an on-going basis.

Section 14.1 Provider Network Development and Management

A. Introduction

Children's Rehabilitative Services (CRS) Contractor must;

1. Maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.
2. Not discriminate with respect to participation in the CRS program, reimbursement, or indemnification against any provider based solely on the provider's type of licensure or certification.
3. Give the affected providers written notice of the reason for its decision if a CRS Contractor declines to include individual or groups of providers in its network. CRS Contractors may not include providers excluded from participation in Federal health care programs.

B. Policies and Procedures

1. CRS Contractor must have policies and procedures in place that pertain to all service specifications specifying how they will:
   a. Immediately notify the Children's Rehabilitative Services Administration (CRSA) in writing when there has been a significant change in operations that would affect adequate capacity and services. The changes include, but are not limited to, changes in services, covered benefits, geographic service areas, payments, or eligibility of a new population.
   b. Communicate with the CRS network providers regarding contractual or program changes and requirements, in writing thirty (30) calendar days prior to the effective date of a program change or any other change in the network, excluding a provider leaving the network (See 42 C.F.R. § 438.10(f)(4)),
   c. Notify affected members of material program changes at least thirty (30) days prior to the effective date of the change (See 42 C.F.R. § 438.10(f)(4)),
   d. Notify affected members within fifteen (15) days of CRS acquiring knowledge that a provider is leaving the network (See 42 C.F.R. § 438.10(f)(5)),
   e. Monitor and ensure network compliance with policies and rules of Arizona Health Care Cost Containment System Administration (AHCCCSA) and CRSA,
   f. Evaluate the quality of services delivered by the network,
   g. Provide or arrange for medically necessary covered services should the CRS provider network become temporarily insufficient,
   h. Monitor network capacity to ensure that there are sufficient providers to handle the volume and needs of CRS members. This includes staff and other resources to handle the language needs involved in the provision of care to CRS recipients with Limited English Proficiency (LEP), and
   i. Ensure service accessibility, including monitoring appointment standards, and appointment waiting times.

2. CRS Contractor shall participate in the development, implementation, and updating of the Statewide CRS Network Development and Management Plan which is submitted to AHCCCS, Division of Health Care Management, forty-five (45) days from the start of each contract year.

C. Provider Network Development and Management Plan

CRS Contractor shall develop and maintain a Provider Network Development and Management Plan, which ensures that the provision of CRSA covered services will occur (See 42 C.F.R. § 438.207(b)). The plan shall be evaluated and updated annually and submitted to CRSA, thirty (30) days from the start of each contract year.

1. The Plan must include the process the CRS Contractor utilizes to ensure:
   a. That covered services are accessible to CRS members in terms of timeliness, amount, duration, and scope.
   b. That covered services are provided promptly and are reasonably accessible in terms of location and hours of operation.
   c. That there shall be sufficient personnel for the provision of all covered services, including emergency medical care on a twenty-four (24) hour a day, seven (7) day a week basis.
2. The Plan must also include a description or explanation of the following:
   a. Evaluation of the prior year's Plan including reference to the success of proposed interventions and/or the need for re-evaluation,
   b. Current status of the network by service type (Hospital, CRS Facility, Specialist, Oral Health, Ancillary Services, etc.) at all levels including:
      i. how members access the system
      ii. relationships between the various levels (e.g., PCP, Specialists, Hospitals)
   c. Current network gaps and the methodology used to identify them,
   d. Immediate short-term interventions when a gap occurs, including expedited or temporary credentialing,
   e. Interventions to fill network gaps and barriers to those interventions,
   f. Outcome measures/evaluation of interventions,
   g. Ongoing activities for network development based on identified gaps and future needs projection, based upon, at a minimum, recipient growth, the number and type of providers that exist in CRS Contractor service area,
   h. Coordination between internal departments,
   i. Coordination with outside organizations,
   j. A description of CRS network design by service area for the general population, including details regarding the CRS member population. The description should cover:
      i. how members access the system,
      ii. relationships between various levels of the system,
      iii. the plan for incorporating the medical home for members and the progress in its implementation
   k. A description of the adequacy of the geographic access to tertiary

hospital services for the Contractor's CRS membership.

l. The assistance provided to PCPs when they refer members to CRS Specialists. The methods used to communicate the availability of this assistance to the providers.

m. An analysis of the Contractors Appointment Availability Report statistics**.**

n. The methodology(ies) the CRS Contractor uses to collect and analyze member, provider and staff feedback about the network designs and performance. When specific issues are identified, the protocols are identified for handling them.

3. The Plan must include answers to the following questions:

a. How does the CRS Contractor assess the medical and social needs of new members to determine how the CRS Contractor may assist the member in navigating the network more efficiently?

b. What assistance is provided to members with a high severity of illness or higher utilization to better navigate the CRS provider network?

c. How does the Contractor support the Graduate Medical Education (GME) programs within its contracted service area and pursue contracting opportunities with graduates and providers that are opening new practices in, or relocating to, Arizona, especially in rural or underserved areas?

d. What interventions has the CRS Contractor implemented to reduce avoidable/preventable emergency room (ER) utilization? What was the outcome of those interventions?

f. Are CRS members allowed to see specialists for their primary care needs? If so, what general criteria are used for this determination?

g. What are the most significant barriers to efficient network deployment within the CRS Contractorôs service area? How can AHCCCS best support the CRS Contractorôs efforts to improve its network and the quality of care delivered to its membership?

h. What interventions has the CRS Contractor implemented to address and reduce no-show rates and how is information collected to assess the efficacy of these measures?

Section 14.2 Communication of Changes

A. Program Changes

Changes in program requirements for providing services, maintaining and reporting data, and complying with contractual agreements must be communicated by the Children's Rehabilitative Services Administration (CRSA) to the Children's Rehabilitative Services (CRS) Contractors with sufficient time to accommodate the change, but no less than thirty (30) calendar days prior to the date the change is to go into effect unless required by law to be enacted sooner. Notification of the change must be in writing and the expected date of compliance must be included.

B. Provider Network Changes

CRS Contractors must give written notice about the termination of a contracted provider, within fifteen (15) days after receipt or issuance of the termination notice, to each recipient who received their primary care from, or is seen on a regular basis by, the terminated provider (See 42 C.F.R. § 438.10(f)(5)). This notice must be provided to CRSA within one (1) business day of the CRS Contractor's knowledge of termination of a contracted provider.

C. Notification of Material Changes

All material changes in the CRS provider network must be approved in advance by CRSA. A "material change" is defined as any change in overall business practice that could have an impact on 5% or more of the recipients, providers, or Arizona Health Care Cost Containment System (AHCCCS) programs, or may significantly impact the delivery of services provided by the CRS Contractor. CRSA must be notified of planned material changes in the provider network before the change process has begun, for example, before issuing a sixty (60)-day termination notice to a provider.

D. Notification of Unexpected Changes

The CRS Contractor shall notify CRSA in writing within one (1) business day for approval of any unexpected changes to its provider network. This notification shall include:

1. Information about how the change will affect the delivery of covered services,
2. The CRS Contractor plans for maintaining the quality of recipient care if the provider network change is likely to result in deficient delivery of covered services, and
3. The CRS Contractor's plan to address and resolve any network deficiencies.
4. The CRS Contractor shall immediately notify CRSA and provide within one (1) business day in writing when there has been a significant change in operations that would affect adequate capacity and services. The changes include, but are not limited to, changes in services, covered benefits, geographic service areas, payments, or eligibility of a new population.

E. Timeliness and Evidence of Notification

1. CRS Contractors must notify providers and recipients in writing thirty (30) calendar days prior to the effective date of a program change or any other change in the network, excluding a provider leaving the network (See 42 C.F.R. § 438.10(f)(4)). The notification letter must be submitted to CRSA forty-five (45) calendar days prior to the effective date of the change for review and approval.
2. Within thirty (30) days of the CRS Contractor communicating a change to the CRS network and/or members, CRS Contractors must provide CRSA with evidence of how the communication with the CRS network and/or members was completed, such as provider/member newsletters, postings on the Web site, etc.

Section 15.1 Corporate Compliance Program

A. Corporate Compliance Written Plan

1. Each Children's Rehabilitative Services (CRS) Contractor shall have a Corporate Compliance Program, supported by a written plan. The plan shall include all seven elements required in 42 C.F.R. § 438.608. The seven (7) elements are:
   a. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards,
   b. The designation of a compliance officer and a compliance committee who are accountable to senior management,
   c. Effective training and education for the compliance officer and an organization's employees,
   d. Effective lines of communication between the compliance officer and the organization's employees,
   e. Enforcement of standards through well-publicized disciplinary guidelines,
   f. Provision for internal monitoring and auditing, and
   g. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Children's Rehabilitative Services Administration (CRSA) contract.
2. In addition, the plan should comply with Federal and State requirements and contain:
   a. Standards of conduct, procedures, internal controls, and system edits for the prevention and detection of fraud and abuse. (See Office of Program Integrity Operations and Procedures Manual).
   b. Policies and procedures that ensure that suspected fraud and program abuse is reported based upon the following requirements:
      i. Upon becoming aware of a suspected incident of fraud or program abuse involving Title XIX/XXI funds or the Arizona Health Care Cost Containment System (AHCCCS) registered providers, including a suspected incident committed by an employee, subcontractor, provider, or recipient, the CRS Contractor or provider has ten (10) working days to inform the AHCCCS/Office of Program Integrity of the suspected fraud or abuse in writing to the address below or by submitting an online form accessible at the link below.

         Arizona Health Care Cost Containment System/Office of Program Integrity
         801 E. Jefferson Street
         Phoenix, Arizona 85034
         http://www.azahcccs.gov/Site/RptFraud.asp

      ii. In addition, the CRS Contractor or providers should advise

the Arizona Department of Health Services (ADHS) Corporate Compliance Officer of the report to AHCCCS by calling or writing to the contact information below.

Arizona Department of Health Services
ADHS Corporate Compliance Officer
150 N. 18th Ave., Suite 280
Phoenix, Arizona 85007
602-364-3758 or 1-866-563-4927
Fax number: 602-364-4736

iii. Upon becoming aware of a suspected incident of fraud or abuse involving State-Only funds, including a suspected incident committed by an employee, subcontractor, provider, or recipient, the CRS Contractor or provider has ten (10) working days to inform the ADHS Corporate Compliance Officer by completing faxing or mailing it to ADHS. Reports of fraud or abuse may also be taken over the phone at 602 364-3758 or 1-866-563-4927.

c. Provision for ensuring compliance with 42 C.F.R. § 438.610 related to prohibited affiliations with individuals debarred by Federal agencies.

d. Provision for ensuring compliance with Public Law 109-171, Section 1902(a) of the Social Security Act, 42 U.S.C. § 1396a related to employee education about false claims recovery.

B. CRS Compliance Officer

Each CRS Contractor shall have a CRS Compliance Officer who reports directly to the CRS Administrator and/or to the parent organizationôs Corporate Compliance Officer and whose responsibilities include:

1. Overseeing, monitoring, and serving as the focal point for the CRS compliance program with the authority to review all documents and functions as they relate to fraud and abuse prevention, detection, and reporting,
2. Maintaining a tracking log, with elements as specified by ADHS Corporate Compliance Officer, of all potential fraud and abuse issues for tracking and trending,
3. Having authority to independently refer potential member and provider fraud and abuse cases to the AHCCCS/OPI and ADHS Corporate Compliance Officer,
4. Having direct access to senior management and legal counsel,
5. Providing training for employees, members, and providers which addresses fraud and program abuse prevention, recognition, and reporting, and encourages trainees to report fraud and abuse without fear of retaliation:
   a. Sign-in sheets must be maintained for all training sessions, and
   b. Fraud and abuse training shall be incorporated into new employee orientation.
6. Attending semi-annual ADHS Corporate Compliance Officer workgroup

meetings held for the purpose of:

a. Discussing compliance issues arising since the last workgroup meeting,
b. Examining new/emerging fraud and program abuse related subjects,
c. Discussing and developing methods for use within the CRS Program to detect and reduce specific types of fraud and program abuse, and
d. Receiving fraud and program abuse related training.

7. Establishing and maintaining a fraud and program abuse hotline. The hotline should allow for anonymous tips and information and should be assessable 24-hours a day, seven days a week (24/7 access does not mean live staffing ï electronic messages and e-mail will be adequate).
8. Attending fraud and abuse training provided by ADHS.

Section 16.1 Business Continuity and Recovery Plan

1. Within ninety (90) days of the beginning of the contract year, staff from each Children's Rehabilitative Services (CRS) Contractor shall submit their Business Continuity and Recovery Plans to the Children's Rehabilitative Services Administration (CRSA) for review and approval.
2. The CRS Contractors' Business Continuity and Recovery Plans shall include planning and training for all the elements contained in the Arizona Health Care Cost Containment System Contractor Operations Manual (ACOM) Business Continuity and Recovery Plan policy (See ACOM Policy 104) including:
   a. Electronic/telephonic failure at the CRS facility,
   b. Loss of primary computer system/records or networks ,
   c. Health care/CRS facility and satellite site closure/Loss of a major CRS provider,
   d. Arranging for medically necessary covered services for CRS members should the CRS facility become temporarily insufficient,
   e. Communication with CRSA in the event of a business disruption,
   f. Communication with key stakeholders regarding a business disruption,
   g. Staff training on the Business Continuity and Recovery Plan, and
   h. Testing of the Business Continuity and Recovery Plan, at least annually.
3. The CRS Contractors shall include in their Business Continuity and Recovery Plans required documentation of the following critical processes:
   a. Eligibility and Enrollment,
   b. Scheduling,
   c. Clinic Visits,
   d. Prior-Authorization,
   e. Surgeries,
   f. Utilization Review/Concurrent Review,
   g. Claims/Provider Payments, and
   h. Grievance/Appeals and Quality of Care Concerns.
4. CRS Contractors are required to notify CRSA of business disruptions and how the disruption will be handled. Notification should include the following:
   a. Description of the disruption,
   b. Plans for dealing with the disruption (for example, how you will reschedule clinic visits/surgeries),
   c. Notification timeline: within twenty-four (24) hours or during the next business day, if disruption begins on a weekend or holiday,
   d. Form of notification: telephone (602) 542-1860 followed in writing via letter to the Division Chief for Compliance at Children's Rehabilitative Services Administration, 150 N. 18th Avenue, Suite #330, Phoenix, AZ 85007-3243, and
   e. Some examples of disruption notification such as loss of major provider, floods, loss of air conditioning, phone, or computer system down time of greater than two (2) days.
5. CRS Contractors will maintain and submit to CRSA within ninety (90) days of the end of the contract year, education tracking forms and sign-in sheets for Business Continuity and Recovery Plan training provided.

6. Within ninety (90) days of the beginning of the contract year, the CRS Contractors shall submit to CRSA their plans for testing their Business Continuity and Recovery Plan detailing timeline for testing and what will be tested. Documentation of the testing performed by the CRS Contractors shall be submitted to CRSA annually.